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Commonwealth of Massachusetts

CERTIFICATE OF BIRTH

FROM THE RECORDS OF BIRTHS IN THE
TOWN OF WINTHROP, MASSACHUSETTS

Date of Birth:	July 11, 1956
Full Name of Child:	Edward Joseph Jones
Sex, Color and if Twin:	M, W, ----
Place of Birth:	Winthrop Community Hospital
Name of Father:	Edmund Jones, Jr.
Maiden Name of Mother:	Eleanor Mary Gallagher
Residence of Parents:	114 Nichols Street, Wilmington, MA
Occupation of Father:	Warehouse Man
Occupation of Mother:	Homemaker
Birthplace of Father:	Boston, MA
Birthplace of Mother:	Boston, MA
Date of Record:	July 13, 1656
Registration No.:	530

I, the undersigned, hereby certify that I am clerk of the Town of Winthrop; that as such I have custody of the records of births required by law to be kept in my office.

And I do hereby certify that the forgoing is a true copy from said records.

Witness my hand and seal of said Town of Winthrop on this 5th day of May 2014

Carla Vitale

Carla Vitale, Town Clerk

ORM R-301

INSTRUCTIONS FOR ICAL CERTIFICATE

In giving ISE OF DEATH

do not enter nore than one ause for each (a), (b) and (c)

is does not mean mode of dying, as heart failure, nia, etc. It means disease, or compli- ns which caused h.

nditions, if any, hich gave rise to ove cause (a), ating the under- ing cause last.

Conditions contrib- g to death but not ed to the terminal se condition given a).

Note:- Chapter 137, cts of 1954 requires hysicians to print or pe the cause or auses of death on eath certificates, and hapter 48, Acts of 959, requires Physi- ians to print or type ame under signature.

M 3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Boston 3-67 Community

PHYSICIAN — IMPORTANT

2 FULL NAME Olivia Panaro (Sgamorra) (Was deceased a U. S. War Veteran, if so specify WAR) No
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 963 Saratoga St. East Boston St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 10 days. In place of residence 34 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. 1 - 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov, 1961, to Dec 31, 1966, I last saw h. alive on Dec 31, 1966, death is said to have occurred on the date stated above, at 10 30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypostatic Pneumonitis	7 days.
Due To (b) Cerebral thrombosis	9 days
Due To (c) Arteriosclerotic hypertensive disease	6 yrs
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Charles Meloni, M. D.
CHARLES MELONI M.D.
(Print or Type Name)
(Address) 45 Bayswater St. E. Boston Date Jan 1 1967

6 St. Michael's Roslindale
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 4 1967

7 NAME OF FUNERAL DIRECTOR Vincent J. Lazzarella
ADDRESS 971 Saratoga St. E.B.

Received and filed JAN. 3 1967 19.....
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐
Female	White	YES ☒ NO ☐	

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Concezio Panaro
(Husband's name in full)

12 DATE OF BIRTH 7/30/1879

13 AGE 87 Years 5 Months 2 Days — If under 24 hours .....Hours.....Minutes

14 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

15 Industry or Business: OWN HOME

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Italy

PARENTS

18 NAME OF FATHER C.N.F.L. SGAMORRA

19 BIRTHPLACE OF FATHER (City) (State or country) ITALY

20 MAIDEN NAME OF MOTHER C.N.F.L.

21 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

22 Informant Olga Panaro
(Address) 963 Saratoga St. E.B.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 1/3/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN -2 '67 PM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 2

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town); No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ABRAHAM BREITMAN (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 208 GROVERS AVE., St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death 2 years ... months ... days. In place of residence 27 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN (Month) 3. (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1956 to JAN. 3, 1967, I last saw him alive on JAN. 2, 1967, death is said to have occurred on the date stated above, at 5:50 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebrovascular Occlusion	1 month
Due To (b) Cerebral arteriosclerosis.	8 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Left Hemiplegia	8 yrs
Arteriosclerotic Heart Disease	8 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN (Print or Type Name)
(Address) WINTHROP, MASS. Date Jan. 3 1967

6 Place of Burial or Cremation: Maple Hill (City or Town) Peabody, Mass.
DATE OF BURIAL Jan. 4, 1967

7 NAME OF FUNERAL DIRECTOR Morris W. Brezniak
ADDRESS 470 Harvard St., Brookline

Received and filed JAN 3 1967 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Rebecca Rubin (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

12 AGE 82 Years ... Months ... Days; If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Manufacturer (Kind of work done during most of working life)

14 Industry or Business: Shoes

15 Social Security No. ~~c/n/b/l/~~ 029-05-5773

16 BIRTHPLACE (City) c/n/b/l/ (State or country) Russia

PARENTS

17 NAME OF FATHER Louis Breitman

18 BIRTHPLACE OF FATHER (City) c/n/b/l/ (State or country) Russia

19 MAIDEN NAME OF MOTHER Esther (unknown)

20 BIRTHPLACE OF MOTHER (City) c/n/b/l/ (State or country) Russia

21 Informant Mr. David Breitman
(Address) 270 Beacon St., Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin (MOH) (Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 1/3/67 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN - 5 '67 P
PM
WI... OF MASS

FORM R-301

d for burial permit
Board of Health
its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

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use for each
a), (b) and (c)

s does not mean
mode of dying,
as heart failure,
sia, etc. It means
isease, or compli-
s which caused
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sditions, if any,
ich gave rise to
ve cause (a),
ting the under-
ng cause last.

Conditions contrib-
to death but not
d to the terminal
e condition given
).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 3

1 PLACE OF DEATH
Suffolk (County) Revere 2-9-67
Winthrop (City or Town)
No. Viking Nursing Home ~~142 Pleasant St.~~ St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ALICE S. KIRKORIAN (Sargent)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 83 Atlantic Ave. St. Revere
(Usual place of abode) (City or town and State)

Length of stay: In place of death 4 years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. 3 - 67
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 10, 1962, to JAN 3, 1967
I last saw he alive on JAN. 3 1967 death is said to have occurred on the date stated above, at 7.55 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CARDIAC DeCompensation	5 days
Due To (b)	ARTERIOSCLEROTIC Heart Disease	5 yrs
Due To (c)	BronchoPneumonitis	10 days
OTHER SIGNIFICANT CONDITIONS	CARDIAC FAILURE	1 day

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Andrew Cutino, M. D.
ANDREW CARINO
(Print or Type Name)
(Address) 603 Broadway Revere Date JAN 4 1967

6 Place of Burial or Cremation Plymouth Cemetery Plymouth N.H. (City or Town)
DATE OF BURIAL Jan. 6, 1967 19..

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike
ADDRESS 305 Beach St. Revere

Received and filed JAN 6 1967 19..
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Harry Kirkorian (Husband's name in full)

12 AGE 79 Years 3 Months 23 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. 024-14-7428B

16 BIRTHPLACE (City) Franklin (State or country) N. H.

PARENTS

17 NAME OF FATHER Herman L. Sargent

18 BIRTHPLACE OF FATHER (City) (State or country) N. H.

19 MAIDEN NAME OF MOTHER Unable to Learn

20 BIRTHPLACE OF MOTHER (City) (State or country) Unable to Learn

21 Informant Harry Kirkorian
(Address) 83 Atlantic Ave. Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (A)
(Signature of Agent of Board of Health or other)
Director Public Health
(Official Designation) (Date of Issue of Permit) 1/6/67

1-6-62-933404

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN -6 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 4

1 PLACE OF DEATH: Suffolk (County) — WINTHROP (City or Town)

No. 26 ALMONT St. - WINTHROP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bessie Bensusan (SHEINKER)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 26 ALMONT St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death 17 years ... months ... days. In place of residence 17 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. (Month) 4 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 1, 1950 to JAN. 4, 1967. I last saw her alive on Jan. 2, 1967, death is said to have occurred on the date stated above, at 10:05 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypertensive and arterio sclerotic Heart Disease	20 yrs.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	15 yrs.
Cerebal Arteriosclerosis	8 yrs.

Was autopsy performed? No

What test confirmed diagnosis Clinical.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN (Print or Type Name)
(Address) WINTHROP, MASS. Date 1/4/ 1967

6 Roxbury Mutual Society WOBURN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JANUARY 5 1967

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home
ADDRESS 420 HARVARD St. - BROOKLINE

Received and filed JAN 5 1967 19...
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of MYER BENSUSAN
(Husband's name in full)

12 AGE 71 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. NONE

16 BIRTHPLACE (City) CHELSEA, (State or country) MASS.

PARENTS

17 NAME OF FATHER DAVID SHEINKER

18 BIRTHPLACE OF FATHER (City) RUSSIA (State or country)

19 MAIDEN NAME OF MOTHER ROSE FINE

20 BIRTHPLACE OF MOTHER (City) RUSSIA (State or country)

21 Informant MYER BENSUSAN
(Address) 26 ALMONT St. - WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health 1/5/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN - 5 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical examiner notified — referral to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 5

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 17 Hawthorne Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank J. Downs
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 17 Hawthorne Ave. St. (City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. (Month) 4 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw him alive on ..., 19..., death is said to have occurred on the date stated above, at 11:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman MD

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date Jan. 4 19 67

6 Place of Burial or Cremation: Winthrop (City or Town): Winthrop

DATE OF BURIAL January 7 19 67

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JAN 6 1967 19...

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Married

11 If married, widowed, or divorced HUSBAND of Agnes LaFreniere
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

12 AGE 52 Years ... Months ... Days; If under 24 hours ... Hours ... Minutes

13 Usual Occupation Chauffeur
(Kind of work done during most of working life)

14 Industry or Business: Cleansing

15 Social Security No. 024-14-7777

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Thomas J. Downs

18 BIRTHPLACE OF FATHER (City) Tarbay (State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Ellen Keary

20 BIRTHPLACE OF MOTHER (City) ... (State or country) Newfoundland

21 Informant Carol Panetta

(Address) 17 Hawthorne Ave

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin Jr.
(Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) Jan 6 1967 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN - 6 '67 PM
CLERK OF THE TOWN CL
WINTHROP, MASS

FORM R-301

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

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cause last.

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to death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 6

PLACE OF DEATH
1 Suffolk (County)
Winthrop (City or Town)
No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Salena Gertrude Belcher
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 34 Pleasant Street St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 6 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. 7 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 1935, to JAN 7, 1967
I last saw he alive on JAN 7, 1967, death is said to have occurred on the date stated above, at 10 30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CEREBRAL HEMORRHAGE	1 DAY
Due To (b)	HYPERTENSION	2 YEARS
Due To (c)	CHRONIC ARTHRITIS	3 YEARS
OTHER SIGNIFICANT CONDITIONS	SENILITY	

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Louis F. Salerno, M. D.
LOUIS F. SALERNO
(Print or Type Name)
(Address) 175 Bussey St Winthrop Date 1/7/67

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 10, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JAN 10 1967
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 82 Years 11 Months 6 Days
If under 24 hours Hours Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business own home

15 Social Security No. 012-16-1939-T

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Warren Emerson Belcher

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Elisabeth Davis

20 BIRTHPLACE OF MOTHER (City) Hamilton
(State or country) East Boston, Mass.

21 Informant E. Foster Belcher
(Address) 230 Lincoln St. Winthrop Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin
(Signature of Agent of Board of Health or other)
Dir of Public Health 1/10/67
(Official Designation) (Date of Issue of Permit)

12-62-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

10 '67 PM

OFFICE OF ... CL
WINTHROP, MASS.

FORM R-301

d for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

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, etc. It means
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which caused

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gave rise to
cause (a),
the under-
cause last.

nditions contrib-
death but not
to the terminal
condition given

-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 7

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 123 QUINCY AVE St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH FALCO
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 123 QUINCY AVE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 24 years ..... months ..... days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 8 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Oct 7, 1966, to January 8, 1967
I last saw him alive on January 8, 1967, death is said to have occurred on the date stated above, at 1:01 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Infarction	30 min
Due To (b) Coronary Artery	yrs
Due To (c) Disease	
OTHER SIGNIFICANT CONDITIONS Peptic ulcer	20 yrs

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify .....

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE
(Print or Type Name)
(Address) 194 Washington ave Winthrop Date 1-10 1967

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)
DATE OF BURIAL JAN 11 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed JAN 10 1967 19.....
John A. Clark
(Registrar)

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: MARRIED

11 If married, widowed, or divorced HUSBAND of PAULINE M MARMINO
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 58 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation UPHOLSTERER
(Kind of work done during most of working life)

14 Industry or Business UPH FURNITURE

15 Social Security No. 021-09-1106

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER BALDAROSSO FALCO

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER ANNA CARRAO

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant MRS PAULINE FALCO
(Address) 123 QUINCY AVE WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (MDK)
(Signature of Agent of Board of Health or other)
Director of Public Health 1/10/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

10 '67 PM

LERK

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 8

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 110 Bayview Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bryana Marie McGough
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 110 Bayview Ave St. (City or town and State)

Length of stay: In place of death 0 years 3 months 2 days. In place of residence 0 years 3 months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. (Month) 8 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/13, 1966 to 1/8, 1967
I last saw he alive on JAN. 6, 1967, death is said to have occurred on the date stated above, at 8:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CONGENITAL HEART DISEASE	3 MOS.
Due To (b) MONGOLISM	3 MOS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) M. Traunstein Jr., M. D.
M. TRAUNSTEIN JR. M.D.
(Print or Type Name)
(Address) 73 BARTLETT RD. WINTHROP, MASS. Date JAN. 8, 1967

6 Mt Pleasant Cemetery Arlington
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 9 1967

7 NAME OF FUNERAL DIRECTOR John E. McAvoy
ADDRESS 223 Mass. Ave. Arlington

Received and filed JAN 9 1967 19
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced HUSBAND of —
(Give maiden name of wife in full)
(or) WIFE of —
(Husband's name in full)

12 AGE 0 Years 3 Months 2 Days — If under 24 hours Hours Minutes

13 Usual Occupation —
(Kind of work done during most of working life)

14 Industry or Business —

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) Winthrop Mass.

PARENTS

17 NAME OF FATHER Thomas J. McGough

18 BIRTHPLACE OF FATHER (City) (State or country) Arlington Mass

19 MAIDEN NAME OF MOTHER June A. DeCourcey

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston Mass.

21 Informant Thomas J. McGough
(Address) 110 Bayview Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (B)
(Signature of Agent of Board of Health or other)
Director of Public Health 1/9/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN - 9 '67 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 9

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Minna Davis Feldman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 80 Sagamore Avenue St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 2 years ..... months ..... days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY (Month) 9, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-3-, 1965, to 1-9-67, 19..... I last saw HER alive on 1-9-67, 19....., death is said to have occurred on the date stated above, at 6:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) UREMIA + CARDIAC DECOMPENSATION — 3 MOS

Due To (b) ARTERIOSCLEROSIS

Due To (c) — 5 MO.

OTHER SIGNIFICANT CONDITIONS: MYXEDEMA. FRACTURE 2ND LUMBAR VERTEBRA — 1 MO.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) A. N. Caplan, M. D.
A. N. CAPLAN MD
(Print or Type Name)
(Address) 186 PRINCETON ST E.B. Date 1-9- 19 67

6 Place of Burial or Cremation: Creration, Woodlawn Crematory, Everet (City or Town)

DATE OF BURIAL January 12, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JAN 11 1967 19.....

John W. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widow

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Abraham Feldman
(Husband's name in full)

12 AGE 69 Years 10 Months 1 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housekeeper
(Kind of work done during most of working life)

14 Industry or Business: private homes

15 Social Security No. 024-14-7958

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Morris Davis

18 BIRTHPLACE OF FATHER (City) (State or country) Poland

19 MAIDEN NAME OF MOTHER Jennie Rose Nathan

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Mary Weisberg

(Address) 80 Sagamore Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin M.D.
(Signature of Agent of Board of Health or other)

Dir of Public Health — Jan 11, 1967
(Official Designation) (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

11 '67 PM
TOWN CLER
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 10

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
Winthrop Community Hospital
No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Boston 2-8-67

2 FULL NAME Concetta (Mainero) Mrs. ~~Notta~~ Santarpio
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 120 Bremen St. St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 50 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 12 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 10, 1966, to Jan 12, 1967
I last saw her alive on Jan 12, 1967, death is said to have occurred on the date stated above, at 1 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinoma of Liver & Metastasis
Due To (b) Carcinoma of Liver & Metastasis
Due To (c)
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

Was autopsy performed? no
What test confirmed diagnosis? Biopsy - Lawrence Memorial Hospital

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Peter J. Ferrino, M. D.
PETER J. FERRINO M.D.
(Print or Type Name)
(Address) 21 BENNINGTON ST E. Boston Date 1-12 1967

6 Place of Burial or Cremation: Holy Cross Cemetery (City or Town) Malden
DATE OF BURIAL January 14 1967

7 NAME OF FUNERAL DIRECTOR Vincent R. Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed JAN 16 1967 19....
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): divorced

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Joseph Santarpio
(Husband's name in full)

12 AGE 54 Years. Months. Days. If under 24 hours: Hours. Minutes.

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country): Boston, Mass.

PARENTS
17 NAME OF FATHER: Frank Mainero
18 BIRTHPLACE OF FATHER (City) (State or country): Italy
19 MAIDEN NAME OF MOTHER: Frances Goduti
20 BIRTHPLACE OF MOTHER (City) (State or country): Italy

21 Informant Frank Santarpio (son)
(Address) 120 Bremen St., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffith
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation)
Jan 13, 1967
(Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN 16 '67 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical Examiner Declined jurisdiction-referred to Winthrop Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 11

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 174 Cottage Park Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary J. Giorgio (Marotta)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 174 Cottage Park Rd. St. Winthrop (City or town and State)

Length of stay: In place of death 26 years ..... months ..... days. In place of residence 26 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably

Due To (b) due to natural

Due To (c) causes.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman, M.D.

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signature) Charles Liberman, M. D.

Charles Liberman (Print or Type Name)

Winthrop Board of Health (Address) 1/21/67 Date ..... 19.....

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 23, 67

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed JAN 23 1967 19.....

John C. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Angelo Giorgio
(Husband's name in full)

12 AGE 57 Years 4 Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. .....

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Lorenzo Marotta

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Vitello

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Italy

21 Informant Angelo Giorgio
(Address) 174 Cottage Park Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin (B)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 1/21/67
(Official Designation) (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN 23 '67 PM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 12

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MRS. ELIZABETH BRADFORD (~~CAMERON~~ KAMMERER)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 16 TAFTS AVENUE St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 70 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 21, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1964, to Jan 21, 1967
I last saw he alive on Jan 20, 1967, death is said to have occurred on the date stated above, at 5:35 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR HEMORRAGE & LEFT HEMIPLEGIA	4 DAYS
Due To (b) ARTERIO-SCLEROTIC & HYPERTENSIVE HEART DIS	5 YRS
Due To (c) CONGESTIVE FAILURE	2 WKS
OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS	3 YRS

Was autopsy performed? NO
What test confirmed diagnosis CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) MYRON N. KING, M. D.
Myron N. King MD
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP, MASS. Date 1/21/ 1967

6 Place of Burial or Cremation WINTHROP (City or Town) WINTHROP

DATE OF BURIAL JAN 25 1967

7 NAME OF FUNERAL DIRECTOR MAURICE H KIRBY

ADDRESS WINTHROP

Received and filed JAN 23 1967 19....
John [illegible] (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of FREDERICK BRADFORD
(Husband's name in full)

12 AGE 84 Years....Months....Days. If under 24 hours: Hours....Minutes

13 Usual Occupation RESTAURANT PROP.
(Kind of work done during most of working life)

14 Industry or Business: RESTAURANT.

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS

PARENTS:
17 NAME OF FATHER CHRISTOPHER KAMMERER
18 BIRTHPLACE OF FATHER (City) GERMANY (State or country)
19 MAIDEN NAME OF MOTHER MARY BAKER
20 BIRTHPLACE OF MOTHER (City) BOSTON, MASS. (State or country)

21 Informant MRS BARBARA BROOKS
(Address) 65 DEACONESS RD BOSTON MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (R)
(Signature of Agent of Board of Health or other)
Dir of Public Health (Official Designation) 1/23/67 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN 23 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

ed for burial permit
Board of Health
r its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
), (b) and (c)

does not mean
mode of dying,
as heart failure,
ia, etc. It means
sease, or compli-
which caused

ditions, if any,
h gave rise to
e cause (a),
ng the under-
g cause last.

nditions contrib-
to death but not
to the terminal
condition given

9-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 13

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home, 170 Cliff Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George A Lawson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. (Usual place of abode) No. 106 ~~Belleveau~~ Bellevue Ave. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 1 years ... months ... days. In place of residence 3 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN (Month) 23 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 28, 1961, to JAN 23, 1967
I last saw him alive on JAN 23, 1967 death is said to have occurred on the date stated above, at 6.15 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 1/2 HR
Due To (b) ARTERIO-SCLEROTIC HEART DIS — 5 YRS.
Due To (c) WITH CONGESTIVE FAILURE
OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased NO
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 222 Pleasant St. WINTHROP MASS Date 1/23 1967

6 Woodlawn Cem. Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 26, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby
ADDRESS Winthrop

Received and filed JAN 26 1967 19..
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of Ella P Kelley
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 79 Years ... Months ... Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation Carpenter
(Kind of work done during most of working life)

14 Industry or Business Bldg. Construction

15 Social Security No. 010-07-3879

16 BIRTHPLACE (City) St. John's (State or country) N.B.

PARENTS

17 NAME OF FATHER Robert E Lawson

18 BIRTHPLACE OF FATHER (City) St. John's (State or country) N.B.

19 MAIDEN NAME OF MOTHER Georgiana Gray

20 BIRTHPLACE OF MOTHER (City) St. John's (State or country) N.B.

21 Informant Mrs Ethel O'Connell
(Address) 106 ~~Belleveau~~ Bellevue Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (B.)
(Signature of Agent of Board of Health or other)
Dir of Public Health
(Official Designation)
Jan 26, 1967
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical examiner notified — referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 11

1 PLACE OF DEATH
Suffolk (County)
WINTHROP (City or Town)
No. 17 Cutler St (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SOLOMON SHAPIRO
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 17 CUTLER St St. WINTHROP (City or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 11:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes.
Due To
(b) Winthrop Board of Health
Due To
(c) Charles Liberman, M.D.

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date Jan. 31 19 67

6 MONTIFIORE EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL FEB 1 1967

7 NAME OF FUNERAL DIRECTOR TORF Funeral Service
ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 2 1967 19.....
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M
9 COLOR White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of EDITH SIEGAL
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 80 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation PRESSER
(Kind of work done during most of working life)

14 Industry or Business: GARMENT

15 Social Security No. 010-10-1454

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER ABRAHAM MOSHE SHAPIRO

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER CBL

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant SARAH MILLER
(Address) 19 CORAL Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin
(Signature of Agent of Board of Health, or other)
Director of Public Health
(Official Designation)
1/31/67
(Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB 2 - '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 15

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MISS FLOPENCE T KEY
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 146 COTTAGE PARK RD St. WINTHROP MASS
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY (Month) 31 (Day), 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 14, 1967, to JAN. 31, 1967.
I last saw he alive on JAN. 30, 1967 death is said to have occurred on the date stated above, at 12:15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL HEMORRHAGE-RT. with LEFT HEMIPLEGIA	17 DAYS
Due To (b) ARTERIOSCEROTIC + HYPERTENSIVE HEART DISEASE	3 YRS.
Due To (c) GENERALIZED ARTERIOSCLEROSIS	5 YRS
OTHER SIGNIFICANT CONDITIONS BILATERAL BRONCHO-PNEUMONIA	5 DAYS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL + LABORATORY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) M. TRAUNSTEIN, JR, M. D.
M. TRAUNSTEIN, JR. M.D.
(Print or Type Name)
(Address) 73 BARTLETT RD WINTHROP, MASS. Date JAN 31, 1967

6 Winthrop
Place of Burial or Cremation
Winthrop (City or Town)
DATE OF BURIAL Feb. 2 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed JAN 31 1967 19.....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 82 Years 4 Months 10 Days | If under 24 hours Hours Minutes

13 Usual Occupation: Teacher retired
(Kind of work done during most of working life)

14 Industry or Business: Public school

15 Social Security No. 013-36-5629

16 BIRTHPLACE (City) (State or country): England

PARENTS

17 NAME OF FATHER: William S Key

18 BIRTHPLACE OF FATHER (City) (State or country): England

19 MAIDEN NAME OF MOTHER: Rose Hopewell

20 BIRTHPLACE OF MOTHER (City) (State or country): England

21 Informant: Lois Haywood
(Address) 1171 Boylston St. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Director of Public Health
(Signature of Agent of Board of Health or other)
Registrar Griffin 1/31/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased bad retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN 31 '8
12
8 7 6
10
ROP. M

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 16

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

Wilton, Ct. 2-8-67

En route to Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: BETSEY (First Name) DREW (Middle Name) TOWER (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 17 Ruscoe Road, St. Wilton, Connecticut (City or town and State)

Length of stay: 1 of death ..... years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: January (Month) 31, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Fracture of skull. Cerebral contusion. Fracture of jaw.

5 Accident, suicide, or homicide (specify) Accident.
Date and hour of injury January 31, 1967. 3:40 A.M.
IF ACCIDENTAL, was injury causally related to the death? Yes.
Where did Injury occur? Winthrop, Massachusetts. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Public Street. (Specify type of place)
Manner of Injury Passenger in motor-car which struck tree. (How did injury occur?)
Nature of Injury
While at work? ..... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 1/31 1967

7 Forest Hills Crematory Boston Mass.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL February 3, 1967

8 NAME OF FUNERAL DIRECTOR J.S.Waterman & Sons
ADDRESS Boston, Mass.

Received and filed FEB 2 1967 19

A TRUE COPY ATTEST: John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female
10 COLOR: White
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

12 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 20 Years 4 Months 13 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Stewardess (Kind of work done during most of working life)

15 Industry or Business: Northeast Airlines

16 Social Security No. 090-38-9418

17 BIRTHPLACE (City) Newton (State or country) Mass.

PARENTS

18 NAME OF FATHER Frederic D.Tower

19 BIRTHPLACE OF FATHER (City) Newton (State or country) Mass.

20 MAIDEN NAME OF MOTHER Martha Chapman

21 BIRTHPLACE OF MOTHER (City) New Bedford (State or country) Mass.

22 Informant (Address) Mr.Frederic D.Tower
17 Ruscoe Road, Wilton, Conn.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin (MCK.)
(Signature of Agent of Board of Health or other)

Director of Public Health 2/2/67
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... FEB 2 - '67 PM .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

..... OFFICE OF THE TOWN CLERK .....

WINTHROP, MASS.

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

OUT OF TOWN

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

17 (City or Town making this return)

Registered No. 00072

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

No. Duplex Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James P. Smitherman (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 95 BEACH RD St. WINTHROP (City or town and State)

Length of stay: In place of death ..... years 6 months ..... days. In place of residence ..... years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 1-2-67 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9-9-66, 19..., to 1-2-67, 19..., I last saw him alive on 1-1-66, 19..., death is said to have occurred on the date stated above, at 9 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute dilatation of Heart	24 hours
Due To (b) Carcinoma of Liver c	
Due To (c) metastasis.	years
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Elia Calicchio, M. D.

Elia Calicchio, M.D. (Print or Type Name)

(Address) 7 Hancock St - Boston Date Jan. 2, 1967

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)

DATE OF BURIAL JAN 5 1966

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS 210 WINTHROP ST WINTHROP, MASS

Received and filed JAN 6 1967 19..

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
MALE	WHITE	MARRIED

11 If married, widowed, or divorced HUSBAND of SARA (CALLAHAN) SMITHERMAN (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 Age 87 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation CARPENTER (Kind of work done during most of working life)

14 Industry or Business GENERAL

15 Social Security No.

16 BIRTHPLACE (City) WINSTON SALEM (State or country) NORTH CAROLINA.

PARENTS

17 NAME OF FATHER UNKNOWN

18 BIRTHPLACE OF FATHER (City) WINSTON - SALEM (State or country) NORTH CAROLINA

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) WINSTON SALEM (State or country) NORTH CAROLINA.

21 Informant JAMES SMITHERMAN

(Address) 95 BEACH RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Emil Cunningham E 8435-2 (Signature of Agent of Board of Health or other)

Jan 4 - 1967 (Official Designation) (Date of Issue of Permit)

15-6
5-7
X71

100M-5-64-938000

A TRUE COPY ATTEST:

TRUE COPY ATTEST:

William J. Kane.

City Registrar

FEB 27 '67 AM

TOWN CLERK
WINTHROP, MASS

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Funeral Director Please use only BLACK Ink.

100M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

18

(City or Town making this return)

Registered No. 00126

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Domenic T. Cardillo, (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 14 Wadsworth Avenue, Winthrop. Massachusetts (City or town and State)

Length of stay: In place of death ..... years ..... months 6 days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 3, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from December 28 1966, to January 3, 1967 I last saw him live on January 3, 1967 death is said to have occurred on the date stated above, at 7.05p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Chronic Cor Pulmonale	1 Year
Due To (b) Pulmonary Fibrosis	10 Years
Due To (c) Asbestosis	20 Years
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy.

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 1-4-67 19

6 Winthrop Cemetery, Winthrop (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL January 7 1967

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston

Received and filed JAN 10 1967 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Josephine Ruggiero (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 66 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired (Kind of work done during most of working life)

14 Industry or Business **********

15 Social Security No. 032-01-5004

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Michael Cardillo

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Carmela Fortunato

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Josephine Cardillo (wife)

(Address) 14 Wadsworth Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

E84427 Kenneth W. Hurd (Signature of Agent of Board of Health or other)

(Official Designation) Jan. 6, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

D — #1

FEB 27 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

UT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

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X70

Funeral Director Please use only BLACK Ink.

100M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

19

(City or Town making this return)

Registered No. C0301

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Angelo P. Screnci (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 51 Sargent Street St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1967, to Jan. 11, 1967

I last saw him alive on Jan. 11, 1967, death is said to have occurred on the date stated above, at 12:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Heart Disease	6 yrs.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Jan. 11 1967

6 St Michaels Boston Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 14 1967

7 NAME OF FUNERAL DIRECTOR Ernest Caggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed JAN 13 1967 19

A TRUE COPY ATTEST: William J. Davis (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

11 If married, widowed or divorced HUSBAND of ELINDA J FAVALORO (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 61 Years 5 Months 18 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired Ins. Salesman (Kind of work done during most of working life)

14 Industry or Business: Insurace

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Peter Screnci

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Elizabeth Wardi

20 BIRTHPLACE OF MOTHER (City) (State or country) Elinda J Screnci 51 Sargent St Winthrop

21 Informant Elinda S Crenci (wife)

(Address) 51 Sargent St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph Flanagan E 04654
(Signature of Agent of Board of Health or other)

(Official Designation) Jan 11, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

t jury

FEB 27 '67 AM

OFFICE OF TH. TOWN CLERK
WINTHROP, MASS.

FORM R-301

JT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

20

(City or Town making this return)

Registered No. C0430

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. Columbus Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anastasia Lawler
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 50 Trident Ave St. Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 14, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1960, to JAN. 14, 1967

I last saw he alive on JAN. 14, 1967, death is said to have occurred on the date stated above, at 10:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYELOID LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertensive Arterio Sclerotic Ht. Disease — 6 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased No

If so, specify

(Signature) Charles Liberman, M. D.

Charles Liberman
(Print or Type Name)

(Address) WINTHROP, MASS. Date 1/14/1967

6 Winthrop — Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 17, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 18 1967, 19..

William J. Dane (Registrar)

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 74 Years. Months. Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation Cook
(Kind of work done during most of working life)

14 Industry or Business: Church Rectory

15 Social Security No.

16 BIRTHPLACE (City) Charlestown (State or country) Mass

PARENTS

17 NAME OF FATHER John Lawler

18 BIRTHPLACE OF FATHER (City) Charlestown (State or country) Mass

19 MAIDEN NAME OF MOTHER Catherine G. McAleney

20 BIRTHPLACE OF MOTHER (City) Portland (State or country) Maine

21 Informant Robert Waidner Sr

(Address) 50 Trident Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Leo E. Morgan / E 04165
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Jan. 16 1967

20 of 1
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100M-9-65-941327

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

FEB 27 '67

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

OUT - OF - TOWN

FORM R-301

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

INT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
enia, etc. It means
disease, or compli-
ns which caused
h.

nditions, if any,
ich gave rise to
ove cause (a),
ting the under-
ing cause last.

Conditions contrib-
to death but not
ed to the terminal
se condition given
a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Chelsea 21
(City or Town making this return)

Registered No. 28

1 PLACE OF DEATH: Suffolk (County) Chelsea. (City or Town)

No. Soldiers' Home Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Frank Anthony Wessling (Frank Anthony WESSLING)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Permanent Residence. No. 27 Enfield St St. Winthrop (City or town and State)

Length of stay: In place of death Hospital — years 1 months 9 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Jan (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1966, to Jan. 21, 1967

I last saw him alive on Jan. 21, 1967, death is said to have occurred on the date stated above, at 7:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Atherosclerotic Heart Disease

Due To (b) (Atherosclerotic heart disease)

Due To (c) (Chronic renal disease)

OTHER SIGNIFICANT CONDITIONS: Chronic Renal Disease

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph R. Dotola, M. D.
JOSEPH R. DOTOLA
(Print or Type Name)

(Address) CHELSEA SOLDIERS HOME Date JAN. 21 1967

6 Holy Cross Cem. Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 24 1967

7 NAME OF FUNERAL DIRECTOR: Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed Jan. 24, 1967

A TRUE COPY ATTEST: [signature] (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Margaret - Arsenault (Give maiden name of wife in full)

(or) WIFE of ——— (Husband's name in full)

12 AGE 70 Years 0 Months 9 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Chauffeur. (Kind of work done during most of working life)

14 Industry or Business: Not known

15 Social Security No. 011-09-2-6548

16 BIRTHPLACE (City) (State or country): S. Boston, Mass.

PARENTS

17 NAME OF FATHER: Bernard Wessling

18 BIRTHPLACE OF FATHER (City) (State or country): Germany.

19 MAIDEN NAME OF MOTHER: Theresa Bogel.

20 BIRTHPLACE OF MOTHER (City) (State or country): Germany

21 Informant: Records - Soldiers Home

(Address) Chelsea. Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph R. Dotola M.D.
(Signature of Agent of Board of Health or other)

AGENT BOARD OF HEALTH (Official Designation) JAN. 21, 1967 (Date of Issue of Permit)

9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 1917. 12. 7.

DATE OF DISCHARGE 1919 - 7. 3.

RANK, RATING Pvt 14"/C Engrs.

ORGANIZATION AND OUTFIT U. S. Army

SERVICE NUMBER 172-425

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) Attending physicians will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) Board of Health physicians will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs, poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB 24 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

RECEIVED
JAN 24 1967
BOARD OF HEALTH

A TRUE COPY ATTEST:

John P. Dalis

Clerk

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 22

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GEORGE J. WADLAND
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 30 BOWDOIN STREET St. WINTHROP, MASSACHUSETTS
(City or town and State)

Length of stay: In place of death.....years.....months 23 days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY (Month) 1, (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN., 1965 to Feb. 1, 1967
I last saw h. alive on Feb. 1, 1967, death is said to have occurred on the date stated above, at 1:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma of Cecum — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? Yes
What test confirmed diagnosis? Pathological, postmortem

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 2/1/1967

6 Place of Burial or Cremation: Winthrop (City or Town) Winthrop
DATE OF BURIAL Feb 4 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St Winthrop

Received and filed FEB 3 1967 19.....
John H. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of Anna G. White
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 67 Years 7 Months 23 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation Retired Milkman
(Kind of work done during most of working life)

14 Industry or Business: Milk

15 Social Security No. 023-09-1846

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER George Wadland

18 BIRTHPLACE OF FATHER (City)
(State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Mary O'Brien

20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country)

21 Informant Mrs Ann Wadland
(Address) 30 Bowdoin St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin
(Signature of Agent of Board of Health or other)
Dir of Public Health 2/3/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 23

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

FULL NAME VICTOR CIPRIANI St. (If death occurred in a hospital or institution, give its NAME instead of street and number) WINTHROP COMMUNITY HOSPITAL

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 79 WINTHROP STREET St. WINTHROP, Mass. (City or town and State)

Length of stay: In place of death ..years..months 3 days. In place of residence 24 years ..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY (Month) 2 (Day), 1967 (Year) ~~1966~~

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1966, to Feb 2, 1967. I last saw him alive on Feb 2, 1967, death is said to have occurred on the date stated above, at 6:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min

Due To (b) Atherosclerosis - generalized — yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS Pulmonary infarct — days

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie M. D.
(Print or Type Name) JOSEPH GREGORIE
(Address) 194 Winthrop St Winthrop Date Feb 2 1967

6 Place of Burial or Cremation WINTHROP (City or Town) Winthrop Mass

DATE OF BURIAL Feb 6 1967

7 NAME OF FUNERAL DIRECTOR Ernest Piaggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed FEB 3 1967 19..

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced HUSBAND of Louise De Santis (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 61 Years 8 Months 8 Days — If under 24 hours ..Hours..Minutes

13 Usual Occupation Shoe Worker (Kind of work done during most of working life)

14 Industry or Business: Shoe Mfg.

15 Social Security No. 022-09-4641

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER John Cipriani

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Lucy Pietrantoni

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Louise (De Santis) Cipriani

(Address) 79 Winthrop St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Griffin (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health
(Official Designation)

2/3/67
(Date of Issue of Permit)

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ailed for burial permit
n Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
nore than one
ause for each
(a), (b) and (c)

is does not mean
e mode of dying,
as heart failure,
nia, etc. It means
eisease, or compli-
ns which caused
.

nditions, if any,
ich gave rise to
ve cause (a),
ting the under-
ng cause last.

Conditions contrib-
to death but not
ed to the terminal
se condition given
).

-9-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 24

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 116 COURT RD St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JEREMIAH E SULLIVAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W W II

(a) Permanent Residence. (Usual place of abode) No. 116 COURT RD St. WINTHROP, Mass. (City or town and State)

Length of stay: In place of death 8 years ..... months ..... days. In place of residence 8 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1960, to Feb. 9, 1967.
I last saw him alive on Feb. 8, 1967, death is said to have occurred on the date stated above, at 7:10a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Advanced rheumatic heart disease with aortic stenosis and mitral insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs
Due To
(b) none
Due To
(c) none

OTHER SIGNIFICANT CONDITIONS Embolism to splenic artery with infarction — 3 wks.

Was autopsy performed? no
What test confirmed diagnosis? clinical & lab.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein, Jr., M. D.
M. Traunstein, Jr., M.D.
(Print or Type Name)
(Address) 73 Bartlett Road Winthrop, Mass. Date 2-10 1967

6 Place of Burial or Cremation WINTHROP (City or Town) WINTHROP
DATE OF BURIAL FEB 11 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP, MASS.

Received and filed FEB 10 1967 19..
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE
9 COLOR WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced
HUSBAND of MARY GOGAN (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 47 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation LAWYER. (Kind of work done during most of working life)

14 Industry or Business LAW, PROBATE

15 Social Security No.

16 BIRTHPLACE (City) SO. BOSTON (State or country) MASS

PARENTS
17 NAME OF FATHER TIMOTHY SULLIVAN
18 BIRTHPLACE OF FATHER (City) IRELAND (State or country)
19 MAIDEN NAME OF MOTHER ANNIE Mc DONOGH.
20 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

21 Informant MARY (GOGAN) SULLIVAN
(Address) 116 COURT RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Griffin (D)
(Signature of Agent of Board of Health or other)
Dir. of Public Health
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... 23 FEB 42 .....

DATE OF DISCHARGE ..... 30 NOV 46 .....

RANK, RATING ..... TEC 5 .....

ORGANIZATION AND OUTFIT ..... INF ARMY .....

SERVICE NUMBER ..... 31067908 .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Revere (City or Town making this return)

Registered No. 25

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town)

No. Ocean View Manor St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Philip L. Anderson (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence No. 11 Summit Ave. St. Winthrop (City or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 43 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 11, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov., 1963, to Feb. 11, 1967

I last saw him alive on ....., 1967, death is said to have occurred on the date stated above, at 4:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebro vascular occlusion	6mons.
Due To (b) Cerebral arterio-sclerosis	2yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Pulmonary tuberculosis	3yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman, M. D.

(Address) Winthrop Shore Dr. Winthrop Date 2/13 1967

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 15 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 8 1967 19

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced HUSBAND of Mary E. Doyle (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 85 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Motorman (Kind of work done during most of working life)

14 Industry or Business: Boston Elevated

15 Social Security No.

16 BIRTHPLACE (City) Malden (State or country) Mass.

PARENTS

17 NAME OF FATHER Patrick J. Anderson

18 BIRTHPLACE OF FATHER (City) Galway (State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen Finnegan

20 BIRTHPLACE OF MOTHER (City) Glasgow (State or country) Scotland

21 Informant Philip L. Anderson, Jr.

(Address) 6 Smith Way, Hingham

A TRUE COPY Joseph [illegible]

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED February 14, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

MAR 8 '67 AM

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 26

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 17 Palmyra St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marion A Kelleher
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 17 Palmyra St., St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 69 years ... months ... days. In place of residence 69 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1963, to 2/11/, 1967
I last saw her alive on 2/10/, 1967, death is said to have occurred on the date stated above, at 10:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
Due To (b) Hypertensive Arterio- — 3 yrs
Due To (c) Sclerotic Heart Disease
OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
Charles Liberman
(Print or Type Name)
(Address) WINTHROP, MASS. Date 2/11/1967

6 Place of Burial or Cremation: St. Mary's Randolph, Mass (City or Town)
DATE OF BURIAL February 14 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed FEB 13 1967 19
John B Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Leo Kelleher
(Husband's name in full)

12 AGE 69 Years ... Months ... Days — If under 24 hours: Hours ... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

PARENTS

17 NAME OF FATHER Joseph L. Visall

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mary J. Crowley

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Leo Kelleher
(Address) 17 Palmyr a Street Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano (?)
(Signature of Agent of Board of Health or other)
Dir of Public Health — Feb 13, 1967
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 27

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 14 Waldemar Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James A. Kirley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 14 Waldemar Ave. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 12 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1964, to Feb. 11, 1967

I last saw him alive on Jan. 3, 1967, death is said to have occurred on the date stated above, at 9:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic heart disease	2½ yrs.
Due To (b) Generalized arteriosclerosis	5 years
Due To (c)	

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) John F. Collins M.D., M. D.

John F. Collins, M. D. (Print or Type Name)

(Address) 27 Pennington St. Revere, Massachusetts 02151. Date Feb. 13, 1967

6 Place of Burial or Cremation: Holy Cross (City or Town) Malden, Mass

DATE OF BURIAL February 14, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed FEB 13 1967 19..

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 78 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Sewer Dept (Kind of work done during most of working life)

14 Industry or Business: Town of Winthrop

15 Social Security No.

16 BIRTHPLACE (City) East Boston (State or country) Mass

PARENTS

17 NAME OF FATHER James Kirley

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER Maria Murray

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

21 Informant Agnes Murphy

(Address) 14 Waldemar Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vlaghans (M.D.) (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) Feb 13 1967 (Date of Issue of Permit)

Medical Examiner Waived Jurisdiction:

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Reported to medical examiner - referred to Board of Health.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 28

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 114 Lincoln Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard B. Page (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) WW 2

(a) Permanent Residence. No. 114 Lincoln Street St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 12 years ..... months ..... days. In place of residence 12 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw him alive on ....., 1967, death is said to have occurred on the date stated above, at 11:02 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

Due To (b) to natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman MD

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Charles Liberman, M. D.

Charles Liberman (Print or Type Name)

(Address) 238 Shore Drive Winthrop, Mass. Date 2/11/1967

6 Winthrop Cemetery, Winthrop (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL February 14, 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed FEB 13 1967 19.....

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Pearl I. Rempel (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 53 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Brakeman retired (Kind of work done during most of working life)

14 Industry or Business: B. & M. Railroad

15 Social Security No. 028-03-3125

16 BIRTHPLACE (City) Brighton (State or country) Mass.

PARENTS

17 NAME OF FATHER Harvey W. Page

18 BIRTHPLACE OF FATHER (City) Danvers (State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine Davis

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Mrs. Pearl I. Page-wife

(Address) 114 Lincoln St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (R) (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) Feb 13, 1967 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....Nov.30,1942.....

DATE OF DISCHARGE.....Feb.13,1946.....

RANK, RATING .....Staff Sgt.....

ORGANIZATION AND OUTFIT.....U. S. Army.....

SERVICE NUMBER.....31 233 372.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
nore than one
ause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
nia, etc. It means
disease, or compli-
ns which caused
s.

nditions, if any,
ich gave rise to
ove cause (a),
ting the under-
ng cause last.

Conditions contrib-
to death but not
ed to the terminal
se condition given
).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 29

1 PLACE OF DEATH: Suffolk (County) — Revere 3-14-67
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME PAUL L. CRUESS
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WW 1

(a) Residence. No. 188 Bellingham Avenue St. Revere
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1966, to Feb. 12, 1967
I last saw him alive on Feb. 12, 1967, death is said to have occurred on the date stated above, at 8:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Carcinoma of liver (Hepatoma) — 2 months

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Evisceration of abdominal wound 2/9/1967

Was autopsy performed? no
What test confirmed diagnosis? Pathology report.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) John F. Collins MD, M. D.
John F. Collins, M. D.
(Print or Type Name)
(Address) 27 Bennington St., Revere, Mass. Date Feb. 13, 1967

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 2/15/67 19

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella
ADDRESS 876 Winthrop Ave., Revere

Received and filed FEB 14 1967 19
John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Marguerite F. Francis
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 67 Years 9 Months 19 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Teacher
(Kind of work done during most of working life)

14 Industry or Business School

15 Social Security No.

16 BIRTHPLACE (City) Waterbury
(State or country) Conn.

PARENTS

17 NAME OF FATHER John F. Cruess

18 BIRTHPLACE OF FATHER (City) New Hartford
(State or country) Conn.

19 MAIDEN NAME OF MOTHER Mary Horan

20 BIRTHPLACE OF MOTHER (City) Cambridge
(State or country) Mass.

21 Informant Marguerite F. Cruess
(Address) 188 Bellingham Ave., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)
Director of Public Health Feb 14, 1967
(Official Designation) (Date of Issue of Permit)

-12-62-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 9/ 30/ 18

DATE OF DISCHARGE 12/ 13/ 18

RANK, RATING Private

ORGANIZATION AND OUTFIT Student Army Training Corps

SERVICE NUMBER 5- 125- 769

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Monson (City or Town making this return)

Registered No. 30

1 PLACE OF DEATH: Hampden (County); Monson Mass. (City or Town)

No. MONSON STATE HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: CLAIRE A. ADAMS (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. Winthrop, Mass. St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 39 years 0 months 21 days. In place of residence 28 years 1 months 19 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February (Month) 13 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h...er live on Feb. 13, 19 67 death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	1 week
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: Epilepsy	61 yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) George M. Reis M.D., M. D.

(Address) Monson State Hospital Date 2/13 19 67

6 Holy Cross Cem. Malden, Mass. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL February 16 19 67

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. E.Boston, Mass.

Received and filed FEB 20 1967 19

John A. Clark

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 67 Years 2 Months 10 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: none (Kind of work done during most working life)

14 Industry or Business: none

15 Social Security No.

16 BIRTHPLACE (City) East Boston, Mass. (State or country)

PARENTS

17 NAME OF FATHER Frederick S. Adams

18 BIRTHPLACE OF FATHER (City) St. Johns (State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Elizabeth A. Dunn

20 BIRTHPLACE OF MOTHER (City) East Boston (State or country) Mass.

21 Informant (Address) Monson State Hospital Records

A TRUE COPY

ATTEST: TOWN CLERK (Registrar of City or Town where death occurred)

Lois L. Tirrell

DATE FILED FEB 15 1967 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FEB 20 '67 AM

OFFICE OF TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 31

1 PLACE OF DEATH

Suffolk (County) Lynn 3-10-67

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Phillip, Ashman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 2 Brimblecomb St., Lynn, Mass. ~~Cliff House Nursing Home~~ St. ~~Winthrop, Mass.~~ (City or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 65 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY (Month) 16, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/20, 1966, to FEB 16, 1967

I last saw h/m alive on 2/15, 1967, death is said to have occurred on the date stated above, at 3 05 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) NEPHROSCLEROSIS WITH UREMIA	1 YR 2 WKS
Due To (b) ARTERIOSCLEROSIS AND ARTERIOSCLEROTIC HEART DIS	5 YRS.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS, BRONCHIECTASIS + EMPHYSEMA	5 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify —

(Signature) Myron N King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 211 PLEASANT ST WINTHROP MASS Date 2/16 1967

6 Pine Grove LYNN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB. 17. 1967

7 NAME OF FUNERAL DIRECTOR Edward M. Hymanson

ADDRESS Lynn, Mass.

Received and filed FEB 16 1967 19....

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	White	(Widower)

11 If married, widowed, or divorced HUSBAND of MIRIAM PERKINS
(Give maiden name of wife in full)

(or) WIFE of ....
(Husband's name in full)

12 AGE 92 Years — Months — Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business: Builder

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER JOSEPH ASHMAN

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER BESSIE C.B.L.

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant MAX ASHMAN

(Address) 9 Oceanside Terrace SWAMPSCOTT

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip L. Pellagiano
(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation)

Feb 16, 1967
(Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
:ause for each
(a), (b) and (c)

iis does not mean mode of dying, as heart failure, enio, etc. It means disease, or compli- ns which coused h.

nditions, if ony, sich gave rise to ove couse (a), iting the under- ing couse last.

Conditions contrib- to death but not ed to the terminal se condition given a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 32

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. The Cliff House Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Cronin
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 162 Washington Ave St. Winthrop Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 3 months 0 days. In place of residence 37 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 16 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1964, to Feb. 16, 1967
I last saw him alive on Feb 15 1967, death is said to have occurred on the date stated above, at 7.50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Heart Disease — yrs
Due To
(b) Arteriosclerosis generalized — yrs
Due To
(c) — yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph F. Gorzel, M. D.
Joseph F. Gorzel
(Print or Type Name)
(Address) 194 Washington Ave Date 2-16 1967

6 Winthrop Winthrop Winthrop
Place of Burial or Cremation Fet. (City or Town)
DATE OF BURIAL Feb 20 1967

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 149 Winthrop St Winthrop

Received and filed FEB 20 1967 19
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 85 Years 11 Months 16 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Laborer
(Kind of work done during most of working life)

14 Industry or Business: Fort Banks

15 Social Security No. 023-16-9685

16 BIRTHPLACE (City) East Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER: John J Cronin

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER: Anna Sullivan

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant: Albert Wyman
(Address) 162 Wash Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano
(Signature of Agent of Board of Health or other)
Dir of Public Health 2/17/67
(Official Designation) (Date of Issue of Permit)

1-9-63-936348

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

o be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Somerville 3-10-67

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 33

1 PLACE OF DEATH
County: SUFFOLK
City or Town: WINTHROP
No. WINTHROP COMMUNITY HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME BELBIN, ALICE M. (LASGUE)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NONE

(a) Permanent Residence. No. 671 SOMERVILLE St. SOMERVILLE, MASS
(City or town and State)

Length of stay: In place of death 0 years 0 months 1 days. In place of residence 16 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1/27, 1967, to FEB 18, 1967
I last saw he alive on FEB 18, 1967, death is said to have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIO-SCLEROTIC HEART DISEASE WITH	5 YRS
Due To (b) CONGESTIVE HEART FAILURE	1 DAY
Due To (c)	
OTHER SIGNIFICANT CONDITIONS 2. PULMONARY INFARCTION	1 DAY

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL + X-ray

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING MD
(Print or Type Name)
(Address) 111 DUCHAINT ST. Date 2/18 1967

6 GETHSEMANE WEST ROXBURY
Place of Burial or Cremation (City or Town)
DATE OF BURIAL FEB 21 1967

7 NAME OF FUNERAL DIRECTOR FRANCIS H. BROWN
ADDRESS 34 BOW ST, SOMERVILLE

Received and filed FEB 20 1967 19...
John A. Clark (Registrar)

A TRUE COPY ATTEST:

N.I.H. EXTRAMURAL DECLINED JURISDICTION

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ALFRED S. BELBIN
(Husband's name in full)

12 AGE 84 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. —

16 BIRTHPLACE (City) NEW BRUNSWICK
(State or country) CANADA

PARENTS

17 NAME OF FATHER HIRAM LASGUE

18 BIRTHPLACE OF FATHER (City)
(State or country) CANADA

19 MAIDEN NAME OF MOTHER JANE WHELPLEY

20 BIRTHPLACE OF MOTHER (City)
(State or country) CANADA

21 Informant ELSIE A RIVERS (DAUGHTER)
(Address) 671 SOMERVILLE AVE, SOMERVILLE

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Cutler
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation)
2/20/67
(Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
ause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
nia, etc. It means
disease, or compli-
ns which caused
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nditions, if any,
hich gave rise to
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ting the under-
ing cause last.

Conditions contrib-
to death but not
ed to the terminal
se condition given
a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 34

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marie J. McGeorge
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 189 Pleasant St. St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 2 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/17/, 1967, to 2/18/, 1967
I last saw he alive on 2/17/, 1967, death is said to have occurred on the date stated above, at 3:10 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral Hemorrhage — 2 Days

Due To (b) Cerebral Arteriosclerosis — 2 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS ARTERIOSCLEROTIC HEART Disease. — 8 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Charles Liberman, M. D.
Charles Liberman
(Print or Type Name)
(Address) WINTHROP, MASS Date 2/18/, 1967

6 Winthrop — Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 21, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed FEB 20 1967, 19..
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William McGeorge
(Husband's name in full)

12 AGE 89 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER Henry Rogers

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Sophia Murphy

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant William McGeorge

(Address) 189 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Director of Public Health — Feb 20, 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

1-12-62-934553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 35

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ada Pepper Tansley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Permanent Residence. No. 110 Grovers Avenue St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ....years 1 months 9 days. In place of residence 40 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG. 20, 1963, to FEB 18, 1967. I last saw her alive on FEB. 17, 1967, death is said to have occurred on the date stated above, at 3:40 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute Myocardial Infarction	5 days
Due To (b)	Arteriosclerotic + Hypertensive heart Disease	5 yrs.
Due To (c)	Generalized Arteriosclerosis	7 yrs.

OTHER SIGNIFICANT CONDITIONS: None

Was autopsy performed? No
What test confirmed diagnosis? Clinical + Laboratory.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) M. Traunstein Jr. M.D.
M. TRAUNSTEIN, JR. M.D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Winthrop, MASS. Date FEB. 18, 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 21, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 21 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widdowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of George Tansley
(Husband's name in full)

12 AGE 86 Years 0 Months 1 Days | If under 24 hours ....Hours ....Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 010-09-6869

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER Thomas Pepper

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Mary Taylor

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Welfare Dept. Records

(Address) Winthrop Town Hall

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health
(Official Designation)

Feb 21, 1967
(Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons),thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 36

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MRS. FREIDA R. PRESCOTT
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Permanent Residence. No. 118 QUINCY AVE. St. WINTHROP MASS. (City or town and State)

Length of stay: In place of death ..years ..months 9 days. In place of residence 40 years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB (Month) 20 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/11, 1967, to 2/20, 1967

I last saw he alive on 2/19, 1967, death is said to have occurred on the date stated above, at 6:00 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion	4 HRS
Due To (b) ARTERIO SCLEROTIC HEART DIS & CONGESTIVE FAILURE	2 YRS
Due To (c) ARTERIOSCLEROSIS & CHRONIC NEPHRITIS	2 YRS
OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS	10 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? —
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 232 PLEASANT ST. WINTHROP MASS. Date 2/20 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 23, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 21 1967

John A Ollard (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Carl O. Prescott
(Husband's name in full)

12 AGE 66 Years 5 Months 19 Days — If under 24 hours ..Hours ..Minutes

13 Usual Occupation Housework
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 023-09-1810-B

16 BIRTHPLACE (City) Milford
(State or country) New Hampshire

PARENTS

17 NAME OF FATHER Frederick Reilly

18 BIRTHPLACE OF FATHER (City) Milford
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Peckinough

20 BIRTHPLACE OF MOTHER (City)
(State or country) Canada

21 Informant Carl O. Prescott

(Address) 118 Quincy Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health — Feb 21, 1967
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

iled for burial permit
n Board of Health
or its Agent.

NSTRUCTIONS
FOR
CAL CERTIFICATE

NT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
ore than one
ause for each
a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
nia, etc. It means
lisease, or compli-
s which caused

nditions, if any,
ich gave rise to
ve cause (a),
ting the under-
g cause last.

Conditions contrib-
to death but not
d to the terminal
e condition given
).

-12-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 37

1 PLACE OF DEATH: Suffolk (County)
Winthrop (City or Town)
No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Laura Anne (Osborne) Bowes
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) -

(a) Residence. No. 789 Shirley Street St.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Feb. (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN., 1955, to Feb. 21, 1967
I last saw her alive on 2/20/, 1967 death is said to have occurred on the date stated above, at 5:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pneumonia	1 wk.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: Generalized Arterio Sclerosis.	10 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 2/21/1967

6 Mount Hope Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 24 1967

7 NAME OF FUNERAL DIRECTOR: Howard S Reynolds
ADDRESS: Winthrop Mass.

Received and filed FEB 23 1967 19
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Arthur F Bowes (Husband's name in full)

12 AGE 99 Years 10 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: House wife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Halifax (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER: Joseph Osborne

18 BIRTHPLACE OF FATHER (City) Halifax (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER: Elizabeth Cleary

20 BIRTHPLACE OF MOTHER (City) Halifax (State or country) Nova Scotia

21 Informant: Francis C Bowes
(Address) 1 Stonehill Dr. Stoneham, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health 2/22/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 38

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RUTLEDGE ~~MR~~ ARTHUR H. (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 35 PROSPECT AVE. St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death ..... years ..... months 9 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec 10, 1966, to Feb 21, 1967

I last saw him alive on 2-20, 1967, death is said to have occurred on the date stated above, at 5 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) hypertensive heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS duodenal ulcer

INTERVAL BETWEEN ONSET AND DEATH: 9 days

Was autopsy performed? no

What test confirmed diagnosis? Ecg. lab

5 Was disease or injury in any way related to occupation of deceased? If so, specify yes - onset shoveling snow

(Signature) H. B. Greenfield, M. D.

H. B. Greenfield (Print or Type Name)

(Address) 447 Shirley St. Winthrop Date 2-21 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 24, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 24 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Gladys Evelyn Whitehead (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 56 Years 5 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Mechanic (Kind of work done during most of working life)

14 Industry or Business: Retail car repair Co.

15 Social Security No. 023-09-5897

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Harry Rutledge

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Elizabeth Dixon

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Mrs. Arthur H. Rutledge

(Address) 35 Prospect Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) Feb 24, 1967 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 39

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Helen Fairfield Tewksbury (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 39 Edgehill Road St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 2 years 3 months ..... days. In place of residence 62 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 22, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1957, to Feb. 22, 1967. I last saw he alive on Feb. 22, 1967 death is said to have occurred on the date stated above, at 4:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Arteriosclerotic hypertensive heart disease	7 yrs.
Due To (b)	Generalized Arteriosclerosis	10 yrs.
Due To (c)	—	
OTHER SIGNIFICANT CONDITIONS	Hypertrophic Arthritis	5 yrs.

Was autopsy performed? No.
What test confirmed diagnosis? Clinical + laboratory.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) M. Traunstein Jr. M. D.
M. TRAUNSTEIN, JR. M.D. (Print or Type Name)
(Address) 73 Bartlett Rd. Winthrop Date Feb. 22 1967

6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 25, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 24 1967 John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Melbourne Banks Tewksbury (Give maiden name of wife in full) (Husband's name in full)

12 AGE 87 Years 6 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housework (Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 018-30-3370

16 BIRTHPLACE (City) Lyme (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Preston L. Fairfield

18 BIRTHPLACE OF FATHER (City) Lyme (State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Churchill

20 BIRTHPLACE OF MOTHER (City) Lyme (State or country) New Hampshire

21 Informant Earl F. Tewksbury
(Address) 39 Edgehill Road

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) Feb 24 1967 (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

N'RUCTIONS FOR C. CERTIFICATE

giving S. OF DEATH

not enter than one for each (b) and (c)

does not mean le of dying, heart failure, etc. It means se, or compli- which caused

ons, if any, gave rise to cause (a), the under- cause last.

ditions contrib- death but not the terminal ondition given

Chapter 137, 1954, requires ns to print or e cause or of death on tificates, and 48, Acts of quires Physi- print or type ter signature.

6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No 46

1 PLACE OF DEATH: SUFFOLK (County) — REVERE 3-10-67
WINTHROP (City or Town)
No. CLIFF HOUSE NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME VINCENT DIGIROLAMO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence No. 35 CRESCENT AVE St REVERE MASS (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years — months — days. In place of residence 3 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JULY 13, 1965, to FEB 24, 1967
I last saw h. alive on FEB 21, 1967, death is said to have occurred on the date stated above, at 1:45 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

Due To (b) ARTERIOSCLEROTIC HEART DIS. / CHRONIC BRONCHITIS

Due To (c) CHRONIC BRONCHITIS / EMPHYSEMA — 3 YRS

OTHER SIGNIFICANT CONDITIONS CHRONIC ARTHRITIS — 3 YRS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N King, M. D.
MYRON N. KING
(PRINT OR TYPE SIGNATURE)
(Address) 22 PLEASANT ST Date 2/24 1967

6 ST MARY'S CEMETERY CANTON MASS
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 2/27/67 19

7 NAME OF FUNERAL DIRECTOR JOSEPH P. ROACHE
ADDRESS 110 SHERMAN ST CANTON MASS.

Received and filed FEB 24 1967 19
John Doe
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M
9 COLOR W
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) WIDOWED

10a If married, widowed, or divorced
HUSBAND of MARY CARCO (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years — Months — Days
If under 24 hours Hours Minutes

13 Usual Occupation: RETIRED (Kind of work done during most of working life)

14 Industry or Business: DRAPER CO.

15 Social Security No. 025-01-3803

16 BIRTHPLACE (City) BARDI (State or country) ITALY

PARENTS

17 NAME OF FATHER PATSY DIGIROLAMO

18 BIRTHPLACE OF FATHER (City) (State or country) ITALY

19 MAIDEN NAME OF MOTHER C. N. B. L.

20 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

21 Informant VINCENT J. DIGIROLAMO
(Address) 35 CRESCENT AVE REVERE MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health 2/24/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

WINTHROP (City or Town making this return)

Registered No. 41

No. 497A Shirley St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME GEORGE (First Name) H. (Middle Name) INGRAHAM (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 497A Shirley Street, Winthrop, Mass. (City or town and State)

Length of stay: I. of death 4 years ... months ... days. In place of residence 4 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 24, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease.
Diabetes mellitus.

5 Accident, suicide, or homicide (specify) ...

Date and hour of injury ... 19...

IF ACCIDENTAL, was injury causally related to the death? ...

Where did Injury occur? ... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)

Manner of Injury ... (How did injury occur?)

Nature of Injury ...

While at work? ... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 2/24 19 67

7 Mt. Auburn Cemetery Cambridge, Mass. Place of Burial or Cremation. (City or Town)

DATE OF BURIAL March 1 19 67

8 NAME OF FUNERAL DIRECTOR Mildred S. Conroy

ADDRESS 439 Washington St., Newton, Mass.

Received and filed FEB 28 1967 19...

A TRUE COPY ATTEST: John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Divorced

12 If married, widowed, or divorced
HUSBAND of Helen Kenney (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

13 AGE 67 Years ... Months ... Days. If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Salesman Ret. (Kind of work done during most of working life)

15 Industry or Business: Insurance Life

16 Social Security No. 023 09 2203

17 BIRTHPLACE (City) Fonda (State or country) New York

PARENTS

18 NAME OF FATHER Howard Ingraham

19 BIRTHPLACE OF FATHER (City) Troy (State or country) New York

20 MAIDEN NAME OF MOTHER Helen (Taylor) Ingraham

21 BIRTHPLACE OF MOTHER (City) Troy (State or country) New York

22 Informant William F. Ingraham
(Address) 152 Brookside Drive
Fairfield, Connecticut

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health Feb 28, 1967
(Official Designation) (Date of Issue of Permit)

MEDICAL

M.A.J.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town ...king this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 42

1 PLACE OF DEATH
Suffolk (County)
WINTHROP (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leo J. MILLER (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 33 Nevada St. WINTHROP, Mass. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 17 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased, from MAY 13, 1957, to FEB 24, 1967. I last saw him alive on FEB 24, 1967, death is said to have occurred on the date stated above, at 1:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH 1/2 HR

Due To (b) ARTERIOSCLEROTIC HEART

Due To (c) DISEASE — 84 Yrs

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D. (Print or Type Name)
(Address) 222 PLEASANT ST. WINTHROP MASS (Date) 2/24 1967

6 Tifereth Is. of Winthrop - Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 26 1967

7 NAME OF FUNERAL DIRECTOR TORF funeral Service Inc

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 27 1967
John B. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of BEATRICE MAGID (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 49 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation DRUGGIST (Kind of work done during most of working life)

14 Industry or Business: Pharmacy

15 Social Security No. 012-09-0387

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

17 NAME OF FATHER MORRIS MILLER

18 BIRTHPLACE OF FATHER (City) (State or country) AUSTRIA

19 MAIDEN NAME OF MOTHER MOLLIE — C.B.L.

20 BIRTHPLACE OF MOTHER (City) (State or country) AUSTRIA

21 Informant Martin MILLER
(Address) 33 Nevada St WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 2/26/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

...ed for burial permit ...ard of Health Agent.

...NSTRUCTIONS FOR ...CAL CERTIFICATE

...NT OR TYPE ...E OR CAUSES ...F DEATH

...o not enter ...ore than one ...use for each ...), (b) and (c)

... does not mean ...node of dying, ...as heart failure, ...ia, etc. It means ...sease, or compli... which caused

...ditions, if any, ...h gave rise to ...e cause (a), ...ng the under... cause last.

...onditions contrib... to death but not ... to the terminal ... condition given

Reported to Med. Examiner. Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

WINTHROP (City or Town making this return)

Registered No. 43

No. 39 PALMYRA STREET SX (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

...LL NAME DONATO CAMPANARO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Re... No. 39 PALMYRA ST. (... place of abode) SX WINTHROP, Mass. (City or town and State)

Length of stay: ... e of death 5 years ... months ... days. In place of residence 5 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: FEB (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 11:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS: Charles Liberman M.D.

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no. If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN M.D. (Print or Type Name)

(Address) 238 SHORE DR. Date 2/26/67

6 WINTHROP CEMETARY (Place of Burial or Cremation) WINTHROP (City or Town)

DATE OF BURIAL 2-MARCH 1967

7 NAME OF FUNERAL DIRECTOR ERNEST P. CAGGIANO

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed MAR 2 1967 19...

John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of FLORENCE FORLANI (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

12 AGE 72 Years 9 Months 26 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation MAINTENANCE (Kind of work done during most of working life)

14 Industry or Business CHILDRENS MED CENTER

15 Social Security No. 031-10-956

16 BIRTHPLACE (City) ITALY (State or country)

PARENTS

17 NAME OF FATHER NICHOLAS CAMPANARO

18 BIRTHPLACE OF FATHER (City) ITALY (State or country)

19 MAIDEN NAME OF MOTHER PASQUALINA MADIO

20 BIRTHPLACE OF MOTHER (City) ITALY (State or country)

21 Informant LENA CAMPANARO

(Address) 39 PALMYRA ST.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Mak) (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 3/1/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

...2-62-934553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

led for burial permit
Board of Health
or its Agent.

NSTRUCTIONS
FOR
CAL CERTIFICATE

NT OR TYPE
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a), (b) and (c)

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as heart failure,
ia, etc. It means
sease, or compli-
: which caused

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h gave rise to
e cause (a),
ng the under-
cause last.

onditions contrib-
to death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 44

1 PLACE OF DEATH: SUFFOLK (County)
WINTHROP (City or Town)

No. VIKING NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNA M (GLEASON) SMITH (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 2 EDGAR TERRACE St. WINTHROP, MASS
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/22/, 1954, to Feb. 26, 1967

I last saw her alive on Feb. 25, 1967, death is said to have occurred on the date stated above, at 5:45a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & hypertensive heart disease	7yrs
Due To (b) Generalized arteriosclerosis	9yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Recurrent phlebitis & cystitis. Chronic gastritis	2yrs

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein, Jr., M. D.
M. Traunstein, Jr., M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop, Mass. Date 2-27 1967

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 1 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP MASS

Received and filed FEB 28 1967 19

John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of FREDERICK R SMITH (Husband's name in full)

12 AGE 86 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOME MAKER (Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. 025-18-5625

16 BIRTHPLACE (City) NEW BRUNSWICK
(State or country) CANADA

PARENTS

17 NAME OF FATHER CHRIS GLEASON

18 BIRTHPLACE OF FATHER (City) NEW BRUNSWICK
(State or country) CANADA

19 MAIDEN NAME OF MOTHER ANNA GIBBONS

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) CANADA

21 Informant DOROTHY E COFFEY

(Address) 2 EDGAR TERRACE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (McK)
(Signature of Agent of Board of Health or other)

Director of Public Health 2/28/67
(Official Designation) (Date of Issue of Permit)

M-63-936348

A TRUE COPY ATTEST

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

331
70

OUT - OF - TOWN

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

45 (City or Town making this return)

Registered No.

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. Peter Bent Brigham Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George Hart (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran if so specify WAR) no

(a) Permanent Residence. No. 2 Edgar Terr. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 27, (Day) 1967. (Year)

4 I HEREBY CERTIFY That We attended deceased from Jan. 22, 1967, to Jan. 27, 1967. We last saw him alive on Jan. 27, 1967, death is said to have occurred on the date stated above, at 2:50 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Subarachnoid hemorrhage	11 days
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) [signature] M. D.
S. Ralph Himmelhoch
(Print or Type Name)

(Address) PBBH Date Jan. 27, 1967.

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 30, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
147 Winthrop St., Winthrop
ADDRESS

Received and filed FEB 1 1967 19

[signature] (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: married

11 If married, widowed, or divorced
HUSBAND of Eva King (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 52 Years 11 Months 13 Days — If under 24 hours Hours Minutes

13 Usual Occupation Maintenance Man (Kind of work done during most of working life)

14 Industry or Business: Simmons College

15 Social Security No. 364 18 3556

16 BIRTHPLACE (City) Alpena (State or country) Mich.

PARENTS

17 NAME OF FATHER John Hart

18 BIRTHPLACE OF FATHER (City) London (State or country) England

19 MAIDEN NAME OF MOTHER Martha Rondeau

20 BIRTHPLACE OF MOTHER (City) Spruce (State or country) Mich.

21 Informant Eva Hart
(Address) 38 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. L. Graca 05444
(Signature of Agent of Board of Health or other)

(Official Designation) Jan. 30, 1967 (Date of Issue of Permit)

100M-9-65-941327

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 14 '67 AM

TOWN CLE
WINTHROP MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

450
85

100M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

CITY OR TOWN

(City or Town making this return) 40

Registered No. 01071

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. New England Deaconess Hospital St. Everett (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mr. Almon E. Whittemore (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 55 Orlando Ave. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 64 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from NOV 3, 1956, to Feb. 1, 1967

I last saw him alive on Jan. 31, 1967, death is said to have occurred on the date stated above, at 1:20 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) RENAL SHUT DOWN	2 DAYS
Due To (b) LT. MID THIGH AMPUTATION	2 DAYS
Due To (c) EMBOLUS TO LT LOW. LEG	2-3 WKS
OTHER SIGNIFICANT CONDITIONS GENERALIZED ARTERIOSCLEROSIS	YRS

Was autopsy performed? YES

What test confirmed diagnosis? PHYSICAL EXAM + LAB TESO

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Carey M Peters, M. D.

CAREY M. PETERS (Print or Type Name)

(Address) 110 FRANCIS ST BOSTON Date 1 FEB 1967

6 Winthrop Cemetery, Winthrop, Mass. (City or Town)
Place of Burial or Cremation

DATE OF BURIAL February 3, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 7 1967

[signature] J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of Adelaide Walker (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 93 Years 4 Months 13 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired banker (Kind of work done during most of working life)

14 Industry or Business: general banking

15 Social Security No. 021-01-3815

16 BIRTHPLACE (City) Medfield (State or country) Massachusetts

PARENTS

17 NAME OF FATHER Edwin Whittemore

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Anna Elizabeth Cleveland

20 BIRTHPLACE OF MOTHER (City) Walpole (State or country) Massachusetts

21 Informant Mrs. Norman W. Davis

(Address) 85 Bartlett Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature] E 05411 (Signature of Agent of Board of Health or other)

(Official Designation) Feb 3 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 21 '67 AM

CLERK

MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: Essex (County) — Danvers (City or town) — Danvers (City or town making this return)

Registered No. 47

Danvers State Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Harold Shifman (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 68 Locust St. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 21 years 10 months 6 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from April 30 61, 19 to February 6 67, 19

I last saw him alive on February 6 67, 19, death is said to have occurred on the date stated above, at 11:25 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Infarction — Mins.

Due To (b) Coronary Occlusion — Mins.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Willard M. Hausman, M. D.
Dr. Willard M Hausman

(Address) Hathorne, Mass Date 2/6 67

6 Share Tefila Cemetery W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 7 67 19

7 NAME OF FUNERAL DIRECTOR: Levine Chapel

ADDRESS: Brookline Mass.

Received and filed ~~Feb. 10~~ MAR 23 1967 19

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

AGE 52 Years 0 Months 22 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Truck drover (Kind of work done during most of working life)

14 Industry or Business: not determined

15 Social Security No. Boston

16 BIRTHPLACE (City) (State or country) Massachusetts

PARENTS

17 NAME OF FATHER: Benjamin Shifman

18 BIRTHPLACE OF FATHER (City) (State or country) Not determined Russia

19 MAIDEN NAME OF MOTHER: Evelyn Lakin

20 BIRTHPLACE OF MOTHER (City) (State or country) Kiev Russia

21 Informant: Helen A Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Tracy I Flagg — Daniel J. Toomey (Registrar of City or Town where death occurred)

Dir. of Public Health 2/7/67

DATE FILED 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

AFFIDAVIT AND CORRECTION OF A RECORD OF DEATH

BOSTON #20 (City or town making return)

48

Registered No. 01284

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. Beth Israel Hospital St., Ward (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ruth Kearney (Hill) (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. 876 Shirley St., Winthrop, Mass. (Usual place of abode) (If nonresident give city or town and state)

Length of stay: In hospital or institution (Specify whether) years months 10 days. In this community 36 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 COLOR: WHITE

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): MARRIED

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

or) WIFE of John H. Kearney (Husband)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 46 Years Months Days If less than 1 day Hours Minutes

9 Usual Occupation: Tel Operator

10 Industry or Business: N.E.Tel. & Tel.

11 Social Security No.

12 BIRTHPLACE (City) (State or country) East Boston Mass

PARENTS

13 NAME OF FATHER Frederick Hill

14 BIRTHPLACE OF FATHER (City) (State or country) E.Boston Mass

15 MAIDEN NAME OF MOTHER Mary E Cahill

16 BIRTHPLACE OF MOTHER (City) (State or country) E.Boston Mass

17 Informant (Address) John H. Kearney ( ) Relation, if any 876 Shirley St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb (Month) 7 (Day) 1967 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1967, to Feb 7, 1967

I last saw her alive on Feb 7, 1967, death is said to have occurred on the date stated above, at 1:15A m.

Immediate cause of death — Duration

Hepatitis and Cirrhosis
Uremia
Due to Peritonitis
Fracture, left ankle
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Date of

Of autopsy No

What test confirmed diagnosis?

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Abraham Gisnburg, M. D.

(Address) 330 Brookline Ave 3/8 1967

21 Place of Burial, Cremation or Removal. (City or Town) Winthrop

DATE OF BURIAL Feb 10 1967

22 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St., Winthrop

Received and filed Feb 13 1967 19

A TRUE COPY ATTEST: (Registrar)

DEPOSITION

WRITE LEGIBLY WITH DURABLE BLACK INK

The Commonwealth of Massachusetts
County of Suffolk } ss.:

The undersigned, being duly sworn, depose and say that the record relating to the death of Ruth Kearney (Give name of decedent exactly as recorded on the original record) in the city (City or town) of Boston (Name of city or town), does not fully and correctly state all the facts relating to said death, and that the true statement of facts omitted or incorrectly stated in said record has been supplied by him (Him or her) on the form of certificate on the other side of this blank.

SIGNATURE	RESIDENCE (City or town, street and number, if any)	Relation to decedent, if any
Abraham Ginsburg	200 Brookline St., Newton	Attending Physician

FURTHER, The written evidence submitted to substantiate the affidavit was:
Attending Physician's medical report shown to correct cause of death.

Date, March 8, 1967

JAN 14 '69 AM

Then personally appeared before me the person whose signature appear above and made oath that the statements subscribed to by him are true.

Name Martha M. Goldrick
Official designation N.P.
(City or town clerk or assistant clerk)

John A Clark

Suffolk (County)

Boston (City or Town)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 43

Registered No. ~~01284~~

No. Beth Israel Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

NAME Ruth Kearney (HILL) PHYSICIAN — IMPORTANT
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

Permanent Residence. No. 876 Shirley St St. Winthrop Mass. (City or town and State)

stay: In place of death ..... years ..... months 10 days. In place of residence 36 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

OF February 7 1967
(Month) (Day) (Year)

REBY CERTIFY That I attended deceased from 27, 1967, to Feb 7, 1967

v her alive on Feb 7, 1967 death is said to

rred on the date stated above, at 1:15 A.m.

WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
~~Alcoholic Cirrhosis~~	
~~Alcoholic Hepatitis~~	
~~Renal Failure~~	
a) Hepatitis and Cirrhosis	
CANT IONS Uremia Peritonitis, Fracture	

opsy performed? No left ankle

st confirmed diagnosis?

isease or injury in any way related to occupation of deceased?

specify Abraham Ginsberg

c) ~~Anthony Robbins~~, M. D.

~~ANTHONY ROBBINS~~
(Print or Type Name)

ess) 330 Brookline Ave Date Feb 7 1967

NTHROP WINTHROP
of Burial or Cremation (City or Town)

E OF BURIAL FEB 10 1967

E OF ERAL DIRECTOR MAURICE W KIRBY

RESS 210 WINTHROP ST. WINTHROP MASS

d and filed FEB 13 1967

Lilliane J. Keane (Registrar)

UE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
FEMALE	WHITE	MARRIED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of JOHN H KEARNEY (Husband's name in full)

12 AGE 46 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation TEL OPERATOR (Kind of work done during most of working life)

14 Industry or Business: N.E. TEL & TELL.

15 Social Security No. .....

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS.

PARENTS

17 NAME OF FATHER FREDERICK HILL

18 BIRTHPLACE OF FATHER (City) EAST BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER MARY E CAHILL

20 BIRTHPLACE OF MOTHER (City) EAST BOSTON (State or country) MASS

21 Informant JOHN H KEARNEY

(Address) 876 SHIRLEY ST, WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature]
(Signature of Agent of Board of Health or other)

E05679 2/9/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 21 [illegible] AM

10
9
8
7

OFFICE
WI

FORM R-303

To be filed for burial permit with Board of Health or Its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

49 (City or Town making this return)

Registered No. 01236

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

OUT-OF-TOWN

En route to East Boston Relief Station Hospital

No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: SALVATORE (First Name) PISCITELLI (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR): no

(a) Permanent Residence. No. 84 Banks Street, St. Winthrop (City or town and State)

Length of stay: I. of death ..... years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February (Month) 7, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute pulmonary edema.

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [signature], M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 2/7 1967

7 Place of Burial or Cremation. Winthrop Cemetery Winthrop (City or Town)
DATE OF BURIAL February 10 1967

8 NAME OF FUNERAL DIRECTOR Anthony P. Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed FEB 1 0 1967 [signature] 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male
10 COLOR: white
11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

12 If married, widowed, or divorced HUSBAND of Lucia Lomuscio (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 72 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired (Kind of work done during most of working life)

15 Industry or Business: ******

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Italy

PARENTS

18 NAME OF FATHER Pasquale Piscitelli

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Sabina Caporale

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant (Address) Lucia Piscitelli (wife)
84 Banks St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[signature] E 05602
(Signature of Agent of Board of Health or other)
Feb 8, 196
(Official Designation) (Date of Issue of Permit)

MEDICAL

A TRUE COPY ATTEST:

William J. Kane

City Registrar

MAR 21 '67 AM

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

584
106

Funeral Directors Please use only BLACK Ink.

100M-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

50
C1670

(City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Callanan
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 66 Shore Drive, St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death — years 1 months — days. In place of residence 8 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 17, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1967, to Feb. 17, 1967, I last saw her alive on Feb. 17, 1967 death is said to have occurred on the date stated above, at 2:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Pulmonary Embolism	10 minutes
Due To (b)	Gastric Ulcer	1 week
	Cholelithiasis	4 weeks
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Acute Tubular Necrosis	10 days
	Pseudomonas Pneumonia	3 weeks

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 17 67 19..

6 Place of Burial or Cremation: Winthrop Cemetery Winthrop (City or Town)
DATE OF BURIAL Feb. 21, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St. Winthrop

Received and filed FEB 27 1967 19..
William J. Lennon (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of James CALLANAN (Husband's name in full)

12 AGE 88 Years — Months — Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. Unknown

16 BIRTHPLACE (City) (State or country): Canada

PARENTS

17 NAME OF FATHER: Peter Rutledge ~~Peter Cochrane~~

18 BIRTHPLACE OF FATHER (City) (State or country): Canada

19 MAIDEN NAME OF MOTHER: Margaret Martin

20 BIRTHPLACE OF MOTHER (City) (State or country): Canada

21 Informant: Edward Callanan
(Address) West Peabody, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
F. B. Greca C06036
(Signature of Agent of Board of Health or other)
(Official Designation) Feb. 18, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 21 '67 AM

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

+20.1
81
X70

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

51 (City or Town making this return)

Registered No. 01652

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. 108 Jersey St., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: RUTH B. MACPHERSON (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 33 Orlando Ave., St. Winthrop Mass (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: FEBRUARY 17 . 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from VIEWED Body, 19..., to ..., 19..., I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at — m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) MYOCARDIAL INFARCTION	
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Pasquale R. Tedeschi, M. D.
PASQUALE R. TEDESCHI (Print or Type Name)
(Address) Boston Health Dept. Date 17 Feb 1967

6 Winthrop (Place of Burial or Cremation) Winthrop, Mass (City or Town)

DATE OF BURIAL February 20, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed FEB 24 1967 19..

William J. Hanes (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Joseph MacPherson (Husband's name in full)

12 AGE 61 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Clerk (Kind of work done during most of working life)

14 Industry or Business: Newspaper Distributors

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER George F. Hesenius

18 BIRTHPLACE OF FATHER (City) Salem (State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Mary E. Mulloy

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

21 Informant Joseph A. MacPherson

(Address) 96 Haverhill St., No Reading

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Flanagan E 00070 (Signature of Agent of Board of Health or other)

(Official Designation) Feb. 19, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 2

M R-305

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MEDFORD
(City or town making return)

Registered No. 52

1 PLACE OF DEATH

MIDDLESEX
(County)

MEDFORD
(City or Town)

No. Lawrence Memorial Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard Carr {(Was deceased a U. S. War Veteran, if so specify WAR)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 49 Prospect Ave., St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence.....8.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary Heart

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

If accidental, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) s/Andrew D. Guthrie, M. D.

(Address) Medford, Mass. Date 2/18 1967

7 Winthrop Winthrop Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL February 21, 1967

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St., Winthrop

Received and filed February 20 1967

Joseph F. McGonagle
(Registrar of City or Town where deceased resided)

CITY CLERK

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED XX WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☐ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Mary (Noone) Carr
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 39 Years.....Months.....Days | If under 24 hours .....Hours .....Minutes

15 Usual Occupation: Truck Driver
(Kind of work done during most of working life)

16 Industry or Business: General Trucking

17 Social Security No. 033-16-7168

18 BIRTHPLACE (City) (State or country) Everett, Mass.

PARENTS

19 NAME OF FATHER Francis J. Carr

20 BIRTHPLACE OF FATHER (City) (State or country) Cambridge Mass.

21 MAIDEN NAME OF MOTHER Emily Melonson

22 BIRTHPLACE OF MOTHER (City) (State or country) Everett, Mass.

23 Informant Mary A. Carr
(Address) 49 Prospect Ave., Winthrop

A TRUE COPY.
ATTEST: Joseph F. McGonagle
(Registrar of City or Town where death occurred)

DATE FILED .....19.....

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

'67 AM

TOWN CLERK

MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

450
85

100M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 50

Registered No. 1827

1 PLACE OF DEATH — OUT-OF-TOWN

Suffolk (County)

EastBoston (City or Town)

No. 17 Gladestone St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eufrasia Anzalone (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 480 Pleasant St. Winthrop (City or town and State)

Length of stay: In place of death ....years 5 months ....days. In place of residence 20 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from October, 1967 to February 21, 1967

I last saw her alive on February 20 1967, death is said to have occurred on the date stated above, at 5-15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic Heart Dis.	Yrs
Due To (b) Gen. Arteriosclerosis	Yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Senility	Yrs.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) D. Thomas Stoffer, M. D.

D. Thomas Stoffer MD (Print or Type Name)

(Address) 21 Breed St. Date February 22 1967

6 Holy Cross Place of Burial or Cremation Malden, Mass. (City or Town)

DATE OF BURIAL Feb. 24 1967

7 NAME OF FUNERAL DIRECTOR William E. Pepi

ADDRESS Pearl St. Malden

Received and filed FEB 27 1967

Nancy J. Manco (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Adolph Anzalone (Husband's name in full)

12 AGE 84 Years ....Months ....Days. If under 24 hours ....Hours ....Minutes

13 Usual Occupation Housework (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. Cn B. L.

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Luigi De Iorio

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Giovannina Forte

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Nina D'Amore

(Address) 17 Gladestone St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

E 6209

(Signature of Agent of Board of Health or other)

(Official Designation)

Feb 23 1967

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 21 '67 AM

OFFICE OF THE TOWN CL
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

452
85

Funeral Director Please use only BLACK Ink.

100M-9-65-941327

CITY OR TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 54

Registered No. 01796

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Helen S. Rubin (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 129 Cliff Ave., St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 20 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1967, to Feb. 21, 1967, and last saw he alive on Feb. 21, 1967, death is said to have occurred on the date stated above, at 1.50 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) SUBARACHNOID HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: DAYS

Due To (b) RUPTURED ANEURYSM OF LEFT POSTERIOR COMMUNICATING ARTERY — DAYS

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Charles L. Clay, M. D., M. D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 21 1967

6 OLD FERETH ISRAEL EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEBRUARY 22, 1967

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERVICE

ADDRESS 87 WASHINGTON ST CHELSEA

Received and filed FEB 27 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): DIVORCED

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of GILBERT RUBIN
(Husband's name in full)

12 AGE 80 Years.... Months.... Days — If under 24 hours .... Hours .... Minutes

13 Usual Occupation AT HOME
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. 023-10-6105

16 BIRTHPLACE (City) SALEM (State or country) MASS

PARENTS

17 NAME OF FATHER MORRIS SHUMAN

18 BIRTHPLACE OF FATHER (City) .... (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER MARGARET COL

20 BIRTHPLACE OF MOTHER (City) .... (State or country) RUSSIA

21 Informant SUMNER GOLDSTEIN

(Address) 12 PRESCOTT ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) FEB 21, 196

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 21 '67 AM

OFFICE OF THE TOWN CLE

WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

434.1
8/2
X70

Funeral Director: Please use only BLACK Ink.

100M-9-65-941327

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Boston 55
(City or Town making this return)

Registered No. 01991

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ella Mason (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 7 Somerset Terrace St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 4 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 22 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1967, to Feb. 22, 1967 I last saw her alive on Feb. 22, 1967, death is said to have occurred on the date stated above, at 12.10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	days
Due To (b) Congestive heart failure	weeks
Due To (c) Complete heart block	weeks
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 22 1967

6 Woodlawn Cemetery, Everett, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 27, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 1 1967

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

12 AGE 76 Years 0 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired secretary (Kind of work done during most of working life)

14 Industry or Business: Law offices

15 Social Security No.

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER Frederick Mason

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Virginia Allen

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Mrs. Marion H. Freeman

(Address) 8 Somerset Terrace, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Eugene Leonard E 66334 (Signature of Agent of Board of Health or other)

(Official Designation) Feb 27 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane

City Registrar

MAR

LERK

MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

420
81
X70

Funeral Directors Please use only BLACK Ink.

.00M-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

(City or Town making this return)

Registered No. 01931

PHYSICIAN — IMPORTANT

2 FULL NAME Susan A. Reardon
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 11 Revere Street, St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 23 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1967, to Feb. 23, 1967 I last saw her alive on Feb. 23, 1967 death is said to have occurred on the date stated above, at 3.55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hypertensive and Arteriosclerotic Heart Disease	4 yrs.
Due To (b)	Hypertension	8 yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. E. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 23, 1967

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)
DATE OF BURIAL February 25, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed MAR 1 1967
William J. Kane (Registrar)

A TRUE COPY ATTEST:

Declined by Medical Examiner

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Female	White	Married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James T. Reardon
(Husband's name in full)

12 AGE 71 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Retired Cleaner
(Kind of work done during most of working life)

14 Industry or Business: Railroad

15 Social Security No.....

16 BIRTHPLACE (City) East Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Peter Christopher

18 BIRTHPLACE OF FATHER (City)..... (State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Bridget Fitzgibbons

20 BIRTHPLACE OF MOTHER (City)..... (State or country) Ireland

21 Informant Dorothy Corbett
(Address) 79 Pleasant St., Revere, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

E 06734
(Signature of Agent of Board of Health or other)

(Official Designation) Feb 24, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane

City Registrar

MAR 21 '67 AM

WINTHROP MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town)

57 (City or Town making this return)

Registered No. 02059

No. New England Medical Center Hospitals St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harold Katz (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Permanent Residence. No. 92 Nahant Avenue St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death ..... years ..... months 11 days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 28 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from February 17, 1967, to February 28, 1967

I last saw him alive on February 28, 1967, death is said to have occurred on the date stated above, at 5:40a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Failure	6 Mos
Due To (b) Cardiomyopathy etiology ?	
Due To (c) ? Scleroderma	
OTHER SIGNIFICANT CONDITIONS Tissue Calcinosis	

Was autopsy performed? No

What test confirmed diagnosis? Clinical Evaluation

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify No

(Signature) Jerome Hantman MD, M. D.

Jerome Hantman MD (Print or Type Name)

(Address) New England Center Hosp Date 2/28 1967

6 Tifereth Israel - Everett (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL March 1 1967

7 NAME OF FUNERAL DIRECTOR Robert Le Vine

ADDRESS 1668 Beacon St. Bkline

Received and filed MAR 3 1967 19

William J. Hane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced HUSBAND of Barbara Kaplan (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 50 Years 2 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation ATTORNEY (Kind of work done during most of working life)

14 Industry or Business Self Employed

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Everett Mass

PARENTS

17 NAME OF FATHER Max Katz

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Mary Levine

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Mrs. Barbara Katz

(Address) 92 Nahant Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature] E06452 (Signature of Agent of Board of Health or other)

March 1 - 1967 (Official Designation) (Date of Issue of Permit)

450.1
81
X70

100M-8-66-943275

TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR
OFFICE OF
WINT

FORM R-301

id for burial permit
Board of Health
its Agent.

FRUCTIONS
FOR
IL CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ease, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

WINTHROP (City or Town making this return)

Registered No. 58

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine Marden (nee Twomey)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 112 Chestnut St. North Reading
(Usual place of abode) (City or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 1 (Day), 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1962, to MARCH 1, 1967
I last saw he alive on FEB 27, 1967, death is said to have occurred on the date stated above, at 10:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5yrs
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 3/1/1967

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 4, 1967

7 NAME OF FUNERAL DIRECTOR Murray & Murray
ADDRESS Beach Street Revere Mass.

Received and filed MAR 3 1967
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Albert Marden
(Husband's name in full)

12 AGE 87 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housewife
(Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No.

16 BIRTHPLACE (City) Ireland
(State or country)

PARENTS

17 NAME OF FATHER John Twomey

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER c/o/1

20 BIRTHPLACE OF MOTHER (City) c/o/1
(State or country)

21 Informant Robert Campbell
(Address) 112 Chestnut St., No. Reading

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Petagliano(s)
(Signature of Agent of Board of Health or other)
Dir. of Public Health — Mar 3, 1967
(Official Designation) (Date of Issue of Permit)

-1-62-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 59

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); Viking Nursing Home; No. 142 Pleasant St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hattie B. Nagle (Frazier) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 90 Lincoln Street St. Winthrop (City or town and State)

Length of stay: In place of death ..years..months 8 days. In place of residence ..years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1966, to March 6, 1967

I last saw her alive on March 5, 1967 death is said to have occurred on the date stated above, at 1:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic Heart disease	1 yr.
Due (b) Generalized arterio-sclerosis	3 yrs
Due To (c) Bilateral thrombo-phlebitis	10mos
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) M. Traunstein Jr., M. D.

M. Traunstein, Jr., M.D. (Print or Type Name)

(Address) 73 Bartlett Rd. Winthrpp, Mass. Date 3-6 1967

6 Place of Burial or Cremation: Holy Cross Cemetery, Malden (City or Town)

DATE OF BURIAL March 9th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 6 1967 19..

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of Horace L. Nagle (Husband's name in full)

12 AGE 78 Years ..Months ..Days. If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 034-16-4840

16 BIRTHPLACE (City) Gloucester (State or country) Mass.

PARENTS

17 NAME OF FATHER: Samuel Frazier

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER: Jane DeCoste

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Nova Scotia

21 Informant Edward J. Nagle-Son

(Address) 22 Penfield Circle, Wakefield

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (S) (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) March 6, 1967 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

...d for burial permit
...oard of Health
Agent.

STRUCTIONS
FOR
AL CERTIFICATE

...T OR TYPE
...E OR CAUSES
...F DEATH

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...nditions contrib-
...o death but not
...e to the terminal
...condition given

Reported to Med. Examiner — referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 60

I PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. VIKING NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

...LL NAME HORACE TOWNSEND
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Re... No. APT. C9 VIKING GARDENS St. WINTHROP, MASS.
(... place of abode) (City or town and State)

Length of stay: ...e of death 6 years ... months ... days. In place of residence 2 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 7 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h...alive on ..., 19..., death is said to have occurred on the date stated above, at 7:30 P.m.

DEATH WAS CAUSED BY: IMMEDIAT... CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably due to
Due To (b) natural causes
Due To (c) WINTHROP BOARD OF HEALTH
OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 3/7/1967

6 WINTHROP CEMETARY WINTHROP, MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 9 1967

7 NAME OF FUNERAL DIRECTOR ERNEST P. CAGGIANO

ADDRESS 147 WINTHROP ST. WINTHROP

Received and filed MAR 9 1967 19...
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE
9 C...OR WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, wi...d, or divorced
HUSBAND of EMMA MITCHELL (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

12 AGE 77 Years 4 Months 21 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation CHEMIST (Kind of work done during most of working life)

14 Industry or Business LEVER BROTHERS

15 Social Security No. 012-10-6139

16 BIRTHPLACE (City) ROBINSTON, MAINE (State or countr...)

PARENTS

17 NAME OF FATHER DUNCAN TOWNSEND

18 BIRTHPLACE OF FATHER (City) MAINE (State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) MAINE (State or country)

21 Informant EMMA TOWNSEND
APT C9 VIKING GARDENS
(Address) WINTHROP, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (s)
(Signature of Agent of Board of Health or other)

Dir of Public Health 3/9/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

...-62-934553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE OCTOBER 4 1917

DATE OF DISCHARGE JANUARY 18 1919

RANK, RATING PRIVAte

ORGANIZATION AND OUTFIT SUPPLY CO. 301st FIELSDARTILLERY

SERVICE NUMBER 1663337

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B. WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100V-9-63-936348

138

X 79

OUT OF TOWN

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61

(City or Town making this return)

Registered No. C2[illegible]

1 PLACE OF DEATH: Suffolk (County) Boston (City or Town)

No. Boston City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ernest Anderson (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 5 Iwin St. Winthrop St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 10 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 10 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Fracture of skull and leg - Meningitis - Auto-accident - Pedestrian - Boston 3-2-67

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Richard Ford M. D. (Print or Type Name)
(Address) Boston, Mass. Date 3-11 1967

7 Winthrop Cem. Winthrop
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL March 15, 1967

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St. Winthrop

Received and filed J. Kane MAR 14 1967 19.....
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male
10 COLOR: white
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

12 If married, widowed, or divorced HUSBAND of Elezabeth Veronica (O'Leary) (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 65 Years — Months — Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: maintenance man (Kind of work done during most of working life)

15 Industry or Business: Carl Hendrick Com. (Lights)

16 Social Security No. not known

17 BIRTHPLACE (City) (State or country) Sweden

PARENTS

18 NAME OF FATHER John Anderson

19 BIRTHPLACE OF FATHER (City) (State or country) sweden

20 MAIDEN NAME OF MOTHER not known

21 BIRTHPLACE OF MOTHER (City) (State or country) Sweden

22 Informant (Address) Elezabeth Anderson 5 Iwin St. Winthrop. Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Eugene Leonard E. 06854
(Signature of Agent of Board of Health or other)
(Official Designation) March 12 1967 (Date of Issue of Permit)

MEDICAL

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAR
WINT

FORM R-301

...ed for burial permit
...Board of Health
... its Agent.

...STRUCTIONS
FOR
...AL CERTIFICATE

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... cause (a),
... the under-
... cause last.

...ditions contrib-
... death but not
...to the terminal
...condition given

...93-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 62

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 3 Chester Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Delphia L (Verrill) Balcom
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 3 Chester Ave. St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 43 years ... months ... days. In place of residence 53 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1966, to MARCH 11, 1967
I last saw her alive on MARCH 11, 1967 death is said to have occurred on the date stated above, at 11:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pneumonia, Bronchial	3 days
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: Arteriosclerotic Heart Disease.	1 yr.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 3/13/1967

6 Park Tilton N.H.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 16 1967

7 NAME OF FUNERAL DIRECTOR: Howard S Reynolds
ADDRESS: Winthrop Mass.

Received and filed MAR 14 1967 19...
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Frank G Balcom
(Husband's name in full)

12 AGE 90 Years 9 Months 5 Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. 033-34-7523

16 BIRTHPLACE (City) Alexandra
(State or country) New Hampshire

PARENTS

17 NAME OF FATHER: George Verrill

18 BIRTHPLACE OF FATHER (City) Alexandra
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER: Sarah Gale

20 BIRTHPLACE OF MOTHER (City) Alexandra
(State or country) New Hampshire

21 Informant: Blanche Noonan
(Address) 3 Chester Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health 3/14/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Canditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 65

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JAMES R. H. LOWSON (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W.W.2

(a) Permanent Residence. No. 160 QUINCY AVENUE., St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death years 2 months 10 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1960, to MARCH 11, 1967

I last saw him alive on MARCH 10, 1967, death is said to have occurred on the date stated above, at 4:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebrovascular Occlusion	3 mos.
Due To (b) ARTERIOSCLEROTIC and HEART DISEASE	10 yrs.
Due To (c) Generalized ARTERIOSCLEROSIS	10 yrs
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Lieberman, M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date 3/11/1967

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop, Mass. (City or Town)

DATE OF BURIAL March 14, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed MAR 14 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Norma Lavern Robinson (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 55 Years 0 Months 6 Days; If under 24 hours Hours Minutes

13 Usual Occupation Branch Officer (Kind of work done during most of working life)

14 Industry or Business: First National Bank

15 Social Security No. 020-14-3539

16 BIRTHPLACE (City) Boston (State or country) Massachusetts

PARENTS

17 NAME OF FATHER David Stewart Lowson

18 BIRTHPLACE OF FATHER (City) (State or country) Scotland

19 MAIDEN NAME OF MOTHER Mary Elizabeth Harrow

20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant Mrs. James R. H. Lowson

(Address) 160 Quincy Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 3/14/67 (Date of Issue of Permit)

C

S.X

DOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... 23 June 42

DATE OF DISCHARGE ..... 4 Jan. 46

RANK, RATING ..... T/Sgt.

ORGANIZATION AND OUTFIT ..... 4108th. AAF Base Unit

SERVICE NUMBER 11 053 968

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 64

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Dr. Frederick Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 11 Bellevue Ave., St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 12 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 12 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec., 1946, to March 12 1967

I last saw him alive on March 11, 1967 death is said to have occurred on the date stated above, at 5 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral vascular accident

Due To (b) arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Congestive heart failure Carcinoma of prostate

INTERVAL BETWEEN ONSET AND DEATH: 12 days; years

Was autopsy performed? No

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) H B Greenfield, M. D.

H. B. Greenfield (Print or Type Name)

447 Shirley St. Winthrop Mass. (Address) Date 3-12 1967

6 Woodlawn Crematory Everett (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL March 15 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed MAR 14 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Harriet Grace Bagloe (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 89 Years 2 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Optometrist (Kind of work done during most of working life)

14 Industry or Business: Private office

15 Social Security No. 028-30-3491

16 BIRTHPLACE (City) Waltham (State or country) Mass.

PARENTS

17 NAME OF FATHER Samuel Stone

18 BIRTHPLACE OF FATHER (City) Nottingham (State or country) England

19 MAIDEN NAME OF MOTHER Susan Reed

20 BIRTHPLACE OF MOTHER (City) Greenville (State or country) Connecticut

21 Informant Harriet Grace Stone

(Address) 11 Bellevue Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 3/14/67 (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ed for burial permit
Board of Health
r its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
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nditions contrib-
o death but not
e to the terminal
condition given

-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 65

1 PLACE OF DEATH: Suffolk
Winthrop
N. CLIFF HOUSE NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Eugene H. McLAUGHLIN (If deceased [illegible] woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Permanent Residence. No. 239 Winthrop Shore Drive Winthrop.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 1 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH, 1966, to MARCH 14, 1967
I last saw him on MARCH 8, 1967, death is said to have occurred on the date stated above, at 6:20 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebrovascular	6 wks.
Due To (b) Occlusion	
Due To (c) Cerebral ARTERIOSCLEROSIS	1 yr
OTHER SIGNIFICANT CONDITIONS Parkinson's	1 yr

Was autopsy performed? No
What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 3/14/1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MARCH 17, 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS 210 Winthrop St. Winthrop

Received and filed MAR 16 1967 19
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of VERA C. LEVERONI
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 70 Years — Months — Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation MED. DEPT U.S VET. ADM.
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 012-07-7171

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS.

PARENTS

17 NAME OF FATHER MICHAEL F. McLAUGHLIN

18 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country) MASS.

19 MAIDEN NAME OF MOTHER JULIA E BUCKLEY ~~IRELAND~~

20 BIRTHPLACE OF MOTHER (City) ~~MISS FRANCES McLAUGHLIN~~
(State or country) IRELAND

21 Informant MISS FRANCES McLAUGHLIN
(Address) 239 Shore Drive Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Wir of Public Health - March 16, 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ....MAY 29, 1918....

DATE OF DISCHARGE ....APRIL 23 1919 MUS 2C....

RANK, RATING ....MUS 2C....

ORGANIZATION AND OUTFIT ....U.S.N. RF....

SERVICE NUMBER ....27291....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 66

1 PLACE OF DEATH: SUFFOLK (County) — Revere 4-7-67
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPHINE A (BRESNAHAN) CONNORS (Was deceased a U. S. War Veteran, if so specify WAR)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 124 CRESCENT AVE St. REVERE MASS (City or town and State)

Length of stay: In place of death ..... years ..... months 10 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from June, 1950, to March 15, 1967
I last saw her alive on March 14, 1967, death is said to have occurred on the date stated above, at 7:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Hemorrhage	2 hrs
Due To (b) Arteriosclerosis	yrs.
Due To (c) Senility	
OTHER SIGNIFICANT CONDITIONS Pernicious Anemia	yrs

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph Gregorie
(Print or Type Name)
(Address) 194 Washington Ave Date 3-15 1967

6 Holyhood Brookline
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 17, 1967. 19

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella
ADDRESS 876 Winthrop Ave., Revere

Received and filed MAR 20 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
FEMALE	WHITE	WIDOW

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Timothy J. Connors (Husband's name in full)

12 AGE 84 Years 7 Months 14 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation At home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Londonberry (State or country) N.H.

PARENTS

17 NAME OF FATHER William H. Bresnahan

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen Haggerty

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Timothy J. Connors
(Address) 10 Deerfield Rd., Norwood

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health, March 16, 1967
(Official Designation) (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medexaminer notified - referred to attending physician.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Boston 4-7-67

1 PLACE OF DEATH: SUFFOLK (County) — WINTHROP, MASS. (City or Town)

WINTHROP, MASS. (City or Town making this return)

Registered No. 67

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MISS. ANNA M. DOYLE (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 31 Moore Street, East Boston St. Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 16 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1965, to March 16, 1967. I last saw her alive on MARCH 16, 1967, death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion	2 days
Due To (b) Hypertensive Arterio-	2 yrs.
Due To (c) Sclerotic Heart Disease	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 3/16/1967

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 18, 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed MAR 20 1967 19

J. [illegible] (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 79 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation School Teacher (Kind of work done during most of working life)

14 Industry or Business: Boston Schools

15 Social Security No. [illegible] 013-36-4142

16 BIRTHPLACE (City) East Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER James Doyle

18 BIRTHPLACE OF FATHER (City) Boston, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Nora O'Connor

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Miss Gertrude F. Doyle
(Address) 31 Moore St. East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 3/17/67
(Official Designation) (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 63

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RALPH GENZALE (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) 2

(a) Permanent Residence. No. 79 HOMER ST. St. EAST BOSTON, MASS. (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Oct, 1965, to March 17, 1967

I last saw him alive on March 16, 1967, death is said to have occurred on the date stated above, at 2:05 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebrovascular Hemorrhage	7 hrs
Due To (b) atherosclerosis - gen	yrs
Due To (c) Hypertension essential	yrs
OTHER SIGNIFICANT CONDITIONS Myocardial Heart disease	yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie, M. D.

Joseph GREGORIE (Print or Type Name)

(Address) 194 Washington St. Winthrop Date 3-17 1967

6 Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 20 1967

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAR 21 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Frances Guerra (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 50 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Police Officer (Kind of work done during most of working life)

14 Industry or Business City of Boston, Division 15

15 Social Security No. 022-01-5253

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Augustino Genzale

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Carmela Genzale (same)

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Frances Genzale (wife)

(Address) 79 Homer St., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B) (Signature of Agent of Board of Health or other)

Dir. of Public Health 3/20/67 (Official Designation) (Date of Issue of Permit)

00M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 1/12/43

DATE OF DISCHARGE 11/30/45

RANK, RATING ..... Shipfitter first class

ORGANIZATION AND OUTFIT ..... U.S. Navy

SERVICE NUMBER 202-86-98

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

TOWN OF WINTHROP
OFFICE OF THE TOWN CLERK

Town Hall, 1 Metcalf Square, Winthrop, MA 02152 Telephone: 617-846-1742 Fax: 617-539-5814

Carla Vitale
Town Clerk

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 69

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 86 Sargent Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Helen Frances Ham(Fowler)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 86 Sargent Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 60 years ..... months ..... days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 6:30 A.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably
Due To (b) due to natural
Due To (c) causes.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health
Charles Liberman MD

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 3/18/ 19 67

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 20, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 20 1967 19.....
John A Clare
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Harold Addison Ham
(Husband's name in full)

12 AGE 74 Years 4 Months 5 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 025-36-7241

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Daniel Fowler

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Annie Layte

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Nova Scotia

21 Informant Harold A. Ham
(Address) 86 Sargent St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir of Public Health 3/20/67
(Official Designation) (Date of Issue of Permit)

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Reported to Med. Examiners office - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 69

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town) — Winthrop (City or Town making this return)

No. 86 Sargent Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Helen Frances Ham (Fowler)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 86 Sargent Street St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 60 years ..... months ..... days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 6:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably

Due To (b) due to natural

Due To (c) causes.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman MD

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 3/18/ 19 67

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 20, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 20 1967 19.....

John McClare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Harold Addison Ham
(Husband's name in full)

12 AGE 74 Years 4 Months 5 Days — If under 24 hours: Hours ..... Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 025-36-7241

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Daniel Fowler

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Annie Layte

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Nova Scotia

21 Informant Harold A. Ham

(Address) 86 Sargent St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health 3/20/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Rowley
(City or Town making this return)

Registered No. 10 70

1 PLACE OF DEATH: Essex (County); Rowley (City or Town)

No. Seaview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herman Lincoln Waldo
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 110 Grovers Ave. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 17, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January, 1967, to March 17, 1967, I last saw him alive on March 17, 1967, death is said to have occurred on the date stated above, at 6:00 A.M.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebral Thrombosis

Due To
(b) Arteriosclerosis

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph R. LaPaglia, M. D.

(Address) Rowley, Mass. Date.....19.....

6 Newton Cemetery Newton, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 20, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed MAR 29 1967 19.....

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 62 Years 2 Months 11 Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 012-03-1698

16 BIRTHPLACE (City) Winthrop, Mass.
(State or country)

PARENTS

17 NAME OF FATHER John Waldo

18 BIRTHPLACE OF FATHER (City) Newton, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Alice Maud

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)

21 Informant Frank Waldo
110 Grovers Ave., Winthrop, Mass.
(Address)

A TRUE COPY
ATTEST: Edward F. MacDonald
(Registrar of City or Town where death occurred)

DATE FILED March 17 19 67

MAR 29 '67 AM

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 141

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 60 Faun Bar Ave., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN CARNEY (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 60 Faun Bar Avenue St. Winthrop (City or town and State)

Length of stay: In place of death 7 years ..... months ..... days. In place of residence 7 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 19, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 12 1967, to March 19, 1967

I last saw him alive on March 18, 1967, death is said to have occurred on the date stated above, at 3.20 p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	48 hrs
Due To (b) Cancer of Lung (Terminal)	1 yr.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Joseph Gregorie, M. D.

Joseph GREGORIE (Print or Type Name)

(Address) 194 Washington Ave. Winthrop Date 3-21 1967

6 Oak Grove Medford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 22, 1967

7 NAME OF FUNERAL DIRECTOR Frank H. Carr

ADDRESS 79 Elm St., Charlestown

Received and filed MAR 21 1967 19

John A Carr (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Teresa McLaughlin (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 66 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Engineer (Ret.) (Kind of work done during most of working life)

14 Industry or Business: Boston Gas Company

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Donegal Ireland

PARENTS

17 NAME OF FATHER John Carney

18 BIRTHPLACE OF FATHER (City) (State or country) Donegal Ireland

19 MAIDEN NAME OF MOTHER Ellen (Carney) Carney

20 BIRTHPLACE OF MOTHER (City) (State or country) Donegal Ireland

21 Informant Mrs. Teresa Carney

(Address) 60 Faun Bar Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health 3/21/67
(Official Designation) (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. [illegible]

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 91 Bartlett Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Arthur James Connelly (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 91 Bartlett Road St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1962, to March 19, 1967

I last saw him alive on 3-18-, 1967, death is said to have occurred on the date stated above, at 6:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Congestive heart failure	15 yrs.
Due To (b)	Rheumatic heart disease	
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	mitral stenosis	

Was autopsy performed? no

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify NO

(Signature) ~~No~~ Threenhold, M. D.

H. B. Greenfield (Print or Type Name)

(Address) 44 Thurston St. Winthrop Mass. Date 3-21 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 22, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 21 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 54 Years 6 Months 23 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired clerk (Kind of work done during most of working life)

14 Industry or Business: Retail Hardware Store

15 Social Security No.

16 BIRTHPLACE (City) East Boston (State or country) Massachusetts

PARENTS

17 NAME OF FATHER James Henry Connelly

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Annie Rachael Callahan

20 BIRTHPLACE OF MOTHER (City) Worcester (State or country) Massachusetts

21 Informant Mrs. Frank E. Fraser

(Address) 63 Waldemar Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B) (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) 3/21/67 (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. [illegible]

1 PLACE OF DEATH: Suffolk (County); Winthrop, Mass (City or Town); No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anita Fontaine (Kelly) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 16 Pearl Avenue St. Winthrop, Mass (City or town and State)

Length of stay: In place of death ..... years ..... months 24 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Sept 22, 1951, to MAR 19, 1967. I last saw her alive on MAR 19, 1967. Death is said to have occurred on the date stated above, at 1205 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR ACCT	12 DAYS
Due To (b) HYPERTENSIVE & ARTERIO-SCLEROTIC HEART DIS	5 YRS
Due To (c) & CONGESTIVE FAILURE	7 mo.
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Myron N. King MD, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date 3/19 1967

6 Place of Burial or Cremation: Winthrop (City or Town)

DATE OF BURIAL MAR. 22 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. McGrath

ADDRESS East Boston

Received and filed MAR 21 1967 19....

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE ~~MALE~~

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Robert Fontaine
(Husband's name in full)

12 AGE 70 Years ..... Months ..... Days. If under 24 hours: Hours ..... Minutes

13 Usual Occupation: House wife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. CNAL

16 BIRTHPLACE (City) (State or country): East Boston MASS.

PARENTS

17 NAME OF FATHER: Charles B. Kelly

18 BIRTHPLACE OF FATHER (City) (State or country): Boston MASS.

19 MAIDEN NAME OF MOTHER: Mary E. Kelly

20 BIRTHPLACE OF MOTHER (City) (State or country): St. John New Brunswick

21 Informant: Ruth C. Kelly
(Address) 16 Pearl Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (MCD)
(Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 3/21/67 (Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 74

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leah Silverman (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. ~~Viking Nursing Home~~ 36 SUMMIT AVENUE St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 2 years ..... months ..... days. In place of residence 33 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1940, to MARCH 21, 1967

I last saw her alive on MARCH 20, 1967, death is said to have occurred on the date stated above, at 8:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART

Due To (b) DISEASE

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date 3/22/1967

6 Forest Hills Crematory Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 23 1967

7 NAME OF FUNERAL DIRECTOR Robert W. LeVine

ADDRESS 1668 Beacon ST. Brookline

Received and filed MAR 24 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Casper Silverman (Husband's name in full)

12 AGE 91 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Austria

PARENTS

17 NAME OF FATHER Samuel Schwartz

18 BIRTHPLACE OF FATHER (City) (State or country) Austria

19 MAIDEN NAME OF MOTHER Sarah (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) (State or country) Austria

21 Informant Mrs. Beatrice Carlson

(Address) 36 Summit Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip D Vitaglione
(Signature of Agent of Board of Health or other)

Dir of Public Health 3/22/67
(Official Designation) (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
Board of Health
its Agent.

TRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
S OR CAUSES
DEATH

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does not mean
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heart failure,
etc. It means
ease, or compli-
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o the terminal
condition given

-1-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 175

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ella Louise Jackson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Residence. No. 36 Bellevue Avenue St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 10 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/21/67, 19 to 3/26/67, 19
I last saw her alive on 3/25/67, 19, death is said to have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Pneumonia	5 Days
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS ARTERIOSCLEROTIC HEART DISEASE	2yrs

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 3/26/ 19 67

6 Place of Burial or Cremation Mt. Hope Cemetery, Boston, Mass. (City or Town)
DATE OF BURIAL March 28, 1967 19

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons
ADDRESS 495 Commonwealth Ave, Boston

Received and filed MAR 27 1967 19
John F. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Arthur Jackson
(Husband's name in full)

12 AGE 92 Years 5 Months 23 Days — If under 24 hours Hours Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Wakefield, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Charles A. Troup

18 BIRTHPLACE OF FATHER (City) Boston, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Clara E. Wheeler

20 BIRTHPLACE OF MOTHER (City) Nashua
(State or country) New Hampshire

21 Informant Mr. Carl Pratt
(Address) 1377 Main St. Lynnfield, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (?)
(Signature of Agent of Board of Health or other)
Dir. of Public Health 3/27/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
ard of Health
Agent.

STRUCTIONS
FOR
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 76

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GEORGE B McGEE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence. No. 10 Wave Way ~~Ave.~~ St. Winthrop
(Usual place of abode) (City or town and State)

Length of stay: In place of death 2 years ..... months ..... days. In place of residence 7 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 5, 1961, to MAR 26, 1967
I last saw h. alive on MAR 26, 1967, death is said to have occurred on the date stated above, at 1.20 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 15 MINS

Due To (b) ARTERIO SCLEROTIC HEART DISEASE WITH CONGESTIVE — 6 YRS

Due To (c) HEART FAILURE
HYPERTENSIVE HEART DIS

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 212 PLEASANT ST WINTHROP MASS Date 3/27 1967

6 Place of Burial or Cremation: Holy Cross Cemetery, Malden (City or Town)
DATE OF BURIAL March 29, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 29 1967 19..
John Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 75 Years 1 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Clerk
(Kind of work done during most of working life)

14 Industry or Business City of Boston

15 Social Security No. 02-4-02

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS
17 NAME OF FATHER John C. McGee
18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.
19 MAIDEN NAME OF MOTHER Agnes M. Ryder
20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Julia J. McGee
10 Wave Way ~~Ave.~~, Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Petagliano (D)
(Signature of Agent of Board of Health or other)
Dir of Public Health 3/29/67
(Official Designation) (Date of Issue of Permit)

-1-62-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE June 5, 1918

DATE OF DISCHARGE June 24, 1922

RANK, RATING Quartermaster 3/c

ORGANIZATION AND OUTFIT Navy

SERVICE NUMBER 132 94 62

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
oard of Health
its Agent.

TRUCTIONS
FOR
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93-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 77

1 PLACE OF DEATH: Suffolk (County) — Malden 4-7-67
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: ABRAHAM HOLZMAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 300 Bryant St. St. Malden, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ....years ....months 7 days. In place of residence 45 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 28 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/22, 1967, to 3/28, 1967
I last saw him alive on 3/28, 1967, death is said to have occurred on the date stated above, at 2:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) GENERAL CARCINOMATOSIS — 5 mo
Due To (b) CARCINOMA OF PANCREAS — 2 yrs
Due To (c)

OTHER SIGNIFICANT CONDITIONS: None

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL + OPERATION

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP MASS Date MAR 28 1967

6 Place of Burial or Cremation: Agudas Achim Cemetery Melrose (City or Town)
DATE OF BURIAL March 28 1967

7 NAME OF FUNERAL DIRECTOR: Murray Goldman
ADDRESS 174 Ferry St. Malden

Received and filed MAR 28 1967 19....
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Married

11 If married, widowed, or divorced
HUSBAND of Ida White
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 74 Years ....Months ....Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Sales- Auto Parts
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 023-01-8719

16 BIRTHPLACE (City) Pinsk (State or country) Poland

PARENTS
17 NAME OF FATHER: Samuel Holzman
18 BIRTHPLACE OF FATHER (City) Pinsk (State or country) Poland
19 MAIDEN NAME OF MOTHER: Ann (Unknown)
20 BIRTHPLACE OF MOTHER (City) Pinsk (State or country) Poland

21 Informant: Harold Holzman
(Address) 26 Essex Road Milton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione (R)
(Signature of Agent of Board of Health or other)
Dir. of Public Health 3/28/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 78

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Viking ~~Rest~~ Home Nursing St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ernest M Call (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 344 Western Ave St. Lynn Mass (City or town and State)

Length of stay: In place of death 1 years ... months 13 days. In place of residence 50 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 31 (Day) - 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 29, 1966, to March 31, 1967

I last saw him alive on March 30, 1967, death is said to have occurred on the date stated above, at 12:10 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart	yrs.
Due To (b) Disease arteriosclerosis - gen	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Amaurosis	yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph Gregorie, M. D.
194 Washington Ave Winthrop
(Print or Type Name)
(Address) Joseph GREGORIE Date 3-31 1967

6 Greenlawn Salem Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 4 1967

7 NAME OF FUNERAL DIRECTOR W.C/Goodrich
ADDRESS 128 Washington St Lynn Mass

Received and filed APR 3 1967 19

John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced
HUSBAND of Unable To Learn (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 82 Years 10 Months 7 Days — If under 24 hours Hours Minutes

13 Usual Occupation Retired (Kind of work done during most of working life)

14 Industry or Business: Employe Boston &Maine R.R.

15 Social Security No 706-09-0876

16 BIRTHPLACE (City) Salem (State or country) Mass

PARENTS

17 NAME OF FATHER Mark Call

18 BIRTHPLACE OF FATHER (City) Unable To Learn (State or country) Unable To Learn

19 MAIDEN NAME OF MOTHER Unable To Learn

20 BIRTHPLACE OF MOTHER (City) Unable To Learn (State or country) Unable To Learn

21 Informant Division OF the Blind
(Address) 39 Boylston St Boston Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health 4/3/67
(Official Designation) (Date of Issue of Permit)

100M-5-64-938000

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers
(City or Town making this return)

Registered No. 73

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Terranova
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 274 Main St. St. Winthrop, Mass
(City or town and State)

Length of stay: In place of death 0 years 3 months 8 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 13 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1966, to March 13, 1967
I last saw him alive on March 13, 1967, death is said to have occurred on the date stated above, at 11:00p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Failure — hrs
Due To
(b) Arteriosclerotic heart Dis. — yrs.
Due To
(c) Generalized Arteriosclerosis — yrs
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signature) Willard M Hausman, M. D.
Dr. Willard M Hausman
(Address) Hathorne, Mass Date 3/13/ 1967

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 17 1967

7 NAME OF FUNERAL DIRECTOR E.P.Caggiano
ADDRESS Winthrop. Mass

Received and filed March 16 67
John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Unknown
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

12 AGE 90 Years 0 Months 25 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: ...

15 Social Security No. 031-07-72-1-A

16 BIRTHPLACE (City) (State or country) Italy

PARENTS
17 NAME OF FATHER Gaetano Terranova
18 BIRTHPLACE OF FATHER (City) (State or country) Italy
19 MAIDEN NAME OF MOTHER Phillipi Lunetta
20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Helen A Ziolkowski
(Address) Danvers, Mass

A TRUE COPY Daniel J. Toomey
ATTEST: Tracy I Flagg
(Registrar of City or Town where death occurred)
DATE FILED Dir. of Public Health 3/14/67 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Canditions contributing to death but not related to the terminal disease canditian given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 80

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sally (Baker) Schlafman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 4 Pico Ave St. Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months 25 days. In place of residence 13 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4 (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAR 24 1967, to APRIL 1, 1967
I last saw her alive on APRIL 1, 1967, death is said to have occurred on the date stated above, at 1:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) GENERAL CARCINOMATOSIS — 2 YRS
Due To (b) CARCINOMA OF BREAST — 7 YRS
Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? PATHOLOGICAL + X-ray

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King M. D.
MYRON N. KING MD
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP MASS Date 4/1 1967

6 Children of Israel Haverhill
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 2, 1967

7 NAME OF FUNERAL DIRECTOR Edward M. Hymanson
ADDRESS Lynn, Mass.

Received and filed APR 4 1967 19.....
John A. Ward (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Henry Schlafman
(Husband's name in full)

12 AGE 50 Years 11 Months 29 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Lawrence, Mass.
(State or country) Mass.

PARENTS

17 NAME OF FATHER Barned Baker

18 BIRTHPLACE OF FATHER (City)
(State or country) Russia

19 MAIDEN NAME OF MOTHER Rose Gedansky

20 BIRTHPLACE OF MOTHER (City)
(State or country) Russia

21 Informant Mark Schlafman-Son
(Address) 4 Pico Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir of Public Health 4/2/67
(Official Designation) (Date of Issue of Permit)

OM-9-65-941327

50 Pleasant St.
Home

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

APR

FORM R-301

d for burial permit
Board of Health
its Agent.

TRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
S OR CAUSES
C DEATH

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does not mean
de of dying,
heart failure,
n, etc. It means
ease, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

C ditions contrib-
death but not
the terminal
condition given
)

Medical examiner notified — referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 81

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 371 Winthrop St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John M. MacCormack
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) yes, WRI

(a) Permanent Residence. No. 371 Winthrop St St. Winthrop Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 50 years — months — days. In place of residence 50 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 2 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 4:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably due to
Due To (b) natural causes,
Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Lieberman M.D.

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 4/3/ 1967

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 5, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St. Winthrop

Received and filed APR 3 1967 19.....
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 76 Years — Months — Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Engineer
(Kind of work done during most of working life)

14 Industry or Business retired

15 Social Security No. 028-16-7294

16 BIRTHPLACE (City) (State or country) Canada

PARENTS

17 NAME OF FATHER John M. MacCormack

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Elezabeth (McLean)

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Mrs. Mary Atherton
(Address) 371 Winthrop St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip E. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 4/3/67
(Official Designation) (Date of Issue of Permit)

-503-936348

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION Feb 11, 1918

DATE OF ENTERING MILITARY SERVICE Feb 11, 1918

DATE OF DISCHARGE Sept. 30, 1921

RANK, RATING Engineman 1c

ORGANIZATION AND OUTFIT USNR

SERVICE NUMBER 133-28-39

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
oard of Health
Agent.

TRUCTIONS
FOR
L CERTIFICATE

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DEATH

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(b) and (c)

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etc. It means
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 82

1 PLACE OF DEATH
Suffolk (County)
WINTHROP (City or Town)
No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Georgia A Cousins (Runnells)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 6 Jefferson St St. WINTHROP Mass
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 3 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from May, 1965, to April 23, 1967, I last saw h alive on April 3, 1967, death is said to have occurred on the date stated above, at 8:35 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — yrs
Due To (b) Arteriosclerosis generalized — yrs
Due To (c)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorio, M. D.
Joseph Gregorio (Print or Type Name)
(Address) 194 Washington Ave Winthrop Date 4-5 1967

6 Church Yard Holderness N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 4 1967

7 NAME OF FUNERAL DIRECTOR Ernest P Baggiano
ADDRESS 147 Winthrop St Winthrop

Received and filed APR 7 1967 19
John E Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ALVAH Cotton Cousins
(Husband's name in full)

12 AGE 85 Years 9 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. —

16 BIRTHPLACE (City) LYME
(State or country) New Hampshire

PARENTS

17 NAME OF FATHER ? Runnells

18 BIRTHPLACE OF FATHER (City) LYME
(State or country) N. H

19 MAIDEN NAME OF MOTHER ?

20 BIRTHPLACE OF MOTHER (City) ?
(State or country)

21 Informant Mrs Esther McCollough
(Address) 66 Shore Dr. WINTHROP Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 4/7/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

162-934553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 83

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Bucknam Paul C. (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW1

(a) Permanent Residence. No. 6 Loring Rd. Winthrop Mass. St. (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL (Month) 4 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from DEC. 18, 1957, to APRIL 4, 1967

I last saw him alive on APRIL 4, 1967 death is said to have occurred on the date stated above, at 8:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE MYOCARDIAL INFARCTION	2 HOURS
Due To (b) Arteriosclerotic + Hypertensive Heart Disease	15 YRS
Due To (c) Generalized Arteriosclerosis	15 YRS
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? NO

What test confirmed diagnosis? Clinical + Laboratory

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) M. Traunstein Jr., M. D.

M. TRAUNSTEIN JR. M.D.

(Print or Type Name)

(Address) 23 BARTLETT RD. WINTHROP MASS. Date April 4, 1967

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)

DATE OF BURIAL April 7 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed APR 7 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Violet Hagman (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 67 Years 5 Months 6 Days — If under 24 hours Hours Minutes

13 Usual Occupation Lighting engineer (retired) (Kind of work done during most of working life)

14 Industry or Business: Electric supply Co.

15 Social Security No. 010-07-7191

16 BIRTHPLACE (City) East Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Alonzo Bucknam

18 BIRTHPLACE OF FATHER (City) Portland (State or country) Maine

19 MAIDEN NAME OF MOTHER Addie Oliver

20 BIRTHPLACE OF MOTHER (City) Portland (State or country) Maine

21 Informant Violet Bucknam

(Address) 6 Loring Rd. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) 4/6/67 (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 3/30/17

DATE OF DISCHARGE 3/29/21

RANK, RATING ..... Seaman

ORGANIZATION AND OUTFIT ..... U S Navy

SERVICE NUMBER 1139300

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

Be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 84

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town); WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number); No. ..... St.

PHYSICIAN — IMPORTANT

2 FULL NAME HELENA (McGINNIS) JACKSON
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Permanent Residence. No. 105 GROVERS AVE St. WINTHROP, MASS
(City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL (Month) 5, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/25, 1967, to 4/5, 1967. I last saw he alive on 4/5/67, 19..., death is said to have occurred on the date stated above, at 2:40 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Hemorrhage	1 wk.
~~Due To~~ (b) Left Hemiplegia	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: Old CVA	2 yrs.

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no.

(Signature) H. D. Potts, M. D.
D. D. Potts, M.D.
(Print or Type Name)
(Address) 12A Bennington St. E.B. Date 4/5 1967

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 8 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed APR 7 1967 19...

John A. Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOW

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Henry M. Jackson
(Husband's name in full)

12 AGE 89 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. .....

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Edward C. McGinness

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen G. Scannell

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

21 Informant Mrs. Philip Monaghan
(Address) 307 Bowdoin St.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 4/7/67
(Official Designation) (Date of Issue of Permit)

10M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or cbanged, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

NSTRUCTIONS FOR C CERTIFICATE

] giving S OF DEATH

do not enter ot than one au for each a) (b) and (c)

h does not mean me of dying, a heart failure, ni etc. It means is se, or compli- ns which caused

ns, if any, ch gave rise to ve cause (a), in the under- g cause last.

ontions contrib- t death but not d the terminal sc ondition given).

ote Chapter 137, o 1954, requires sic ns to print or e cause or es of death on h rtificates.

Medical examiner notified - referred to Board of Health.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 85

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 100 FREMONT ST. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: EILEEN AGNES CORLISS (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 100 FREMONT St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years months days. In place of residence 6 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 8 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 5:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes, probably

Due To (b) acute coronary occlusion

Winthrop Board of Health

Due To (c) Charles Liberman

OTHER SIGNIFICANT CONDITIONS: CHARLES LIBERMAN

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles Liberman, M. D.

CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 4/8/ 1967

6 SAINT PATRICK'S AMHERST N.H.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 11 1967

7 NAME OF FUNERAL DIRECTOR: SMITH AND HEALD

ADDRESS: 37 ELM ST, MILFORD, N.H.

Received and filed APR 10 1967 19.....

John A Clair (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: CAUCASIAN

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of MOODEY BELL CORLISS (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years 3 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) (State or country): MILFORD NEW HAMPSHIRE

PARENTS

17 NAME OF FATHER: Peter F. CLARKIN

18 BIRTHPLACE OF FATHER (City) (State or country): CO CANON, IRELAND

19 MAIDEN NAME OF MOTHER: ALICE GARITY

20 BIRTHPLACE OF MOTHER (City) (State or country): MILFORD NEW HAMPSHIRE

21 Informant (Address): MOODEY BELL CORLISS 100 FREMONT STREET

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (B)

(Signature of Agent of Board of Health or other)

Director of Public Health April 8, 1967

(Official Designation) (Date of Issue of Permit)

100M-11-55-91

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourte n, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: Worcester (County) — Gardner (City or Town) — Gardner (City or Town making this return)

Registered No. 86

No. Henry Heywood Mem. Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Freda Ann (Novosel) Koumanelis (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence No. 236 Lincoln St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 17 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 10 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

1. Multiple Rib Fractures
2. Fracture of Sternum
3. Internal Chest Injuries

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 1:00p.m. 4/7 19 67

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Templeton, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? State Highway (Specify type of place)

Manner of Injury Car Collision (How did injury occur?)

Nature of Injury Chest Injuries

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Joseph P. Marnane, M. D.

(Address) Gardner, Mass. Date 4/10 1967

7 Oak Grove Cem. Medford, Mass. Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 13 19 67

8 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed ..... 19 .....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William Koumanelis (Husband's name in full)

13 AGE 45 Years 10 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housework (Kind of work done during most of working life)

15 Industry or Business: Own Home

16 Social Security No. 017-16-0964

17 BIRTHPLACE (City) (State or country) Somerville Mass.

PARENTS

18 NAME OF FATHER John Novosel

19 BIRTHPLACE OF FATHER (City) (State or country) Austria

20 MAIDEN NAME OF MOTHER Emma Last

21 BIRTHPLACE OF MOTHER (City) (State or country) Germany

22 Informant (Address) William Koumanelis 236 Lincoln St., Winthrop, Mass.

A TRUE COPY

ATTEST: Gina J Pacocha (Registrar of City or Town where death occurred)

DATE FILED April 14 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

APR 25 '67 AM

CLERK
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 87

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Charles H Mitton

2 FULL NAME Charles H. Mitton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 6 Jefferson St. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 10 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1965, to April 10, 1967. I last saw him alive on April 8, 1967, death is said to have occurred on the date stated above, at 3:46 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

Due To (b) Arteriosclerosis generalized — yrs

Due To (c) — yrs

OTHER SIGNIFICANT CONDITIONS Senility — yrs

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Joseph Gregoire, M. D.
Joseph GREGOIRE (Print or Type Name)
(Address) 194 Washington St. Winthrop, Mass. Date 4/10 1967

6 Place of Burial or Cremation: Lincoln (City or Town) Lincoln Maine

DATE OF BURIAL April 14th 67 19....

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop. Mass.

Received and filed APR 12 1967 19....

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Ann Kennedy (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 95 Years 5 Months 12 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Barber (Kind of work done during most of working life)

14 Industry or Business: Self employed

15 Social Security No. 007-30-5227

16 BIRTHPLACE (City) Lee (State or country) Maine

PARENTS

17 NAME OF FATHER Hozin Mitton

18 BIRTHPLACE OF FATHER (City) Unable to obtain (State or country) Canada

19 MAIDEN NAME OF MOTHER Emily Lee

20 BIRTHPLACE OF MOTHER (City) Lee (State or country) Maine

21 Informant James Mitton
(Address) 156 East 79th St. New York City

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Signature of Agent of Board of Health or other)

Dir of Pub Health (Official Designation) 4/12/67 (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

fid for burial permit
hboard of Health
its Agent.

INSTRUCTIONS FOR IC. CERTIFICATE

IN OR TYPE
SIOR CAUSES
O DEATH

do not enter
nc than one
ate for each
(a (b) and (c)

is does not mean
nle of dying,
heart failure,
ni etc. It means
dise, or compli-
ns which caused
h.

nd ons, if any,
nic gave rise to
ovi cause (a),
ntis the under-
ing cause last.

Co itions contrib-
t death but not
ed the terminal
se ondition given
a).

-1202-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 88

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 58 Thornton Park St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William John Cooper
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 58 Thornton Park St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 5 years months days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1964, to APRIL 11, 1967
I last saw him alive on APRIL 11, 1967, death is said to have occurred on the date stated above, at 5:40 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	NEPHROSCLEROSIS WITH UREMIA	1 MO
Due To (b)	ARTERIOSCLEROTIC HEART DIS WITH CONGESTIVE FAILURE	3 YRS.
Due To (c)	+ MYOCARDIAL ISCHEMIA	
OTHER SIGNIFICANT CONDITIONS	CHRONIC BRONCHITIS	5 YRS.

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 22 PLEASANT ST WINTHROP MASS Date APRIL 11, 1967

6 Place of Burial or Cremation St Josephes St John N.B. (City or Town)
DATE OF BURIAL April 15 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass.

Received and filed APR 12 1967
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of S Mae Quinn
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 89 Years 5 Months 18 Days
If under 24 hours Hours Minutes

13 Usual Occupation Clerk (retired)
(Kind of work done during most of working life)

14 Industry or Business Tobacco Store

15 Social Security No. None

16 BIRTHPLACE (City) Coldbrook
(State or country) New Brunswick

PARENTS

17 NAME OF FATHER William T Cooper

18 BIRTHPLACE OF FATHER (City) Halifax
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Mary Palmer

20 BIRTHPLACE OF MOTHER (City) St John
(State or country) New Brunswick

21 Informant Marion Thomas
(Address) 58 Thornton Park Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip D Vitaglione MD
(Signature of Agent of Board of Health or other)

Dir of Public Health
(Official Designation)

4/12/67
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical examiner notified — Referred to Board of Health.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 83

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sylvester Ranalli (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 141 Meridian St. East Boston Mass. (City or town and State)

Length of stay: In place of death 11 years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 11 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw him alive on ....., 19....., death is said to have occurred on the date stated above, at 2:15 P.M.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes, probably

Due To (c) Recurrent cerebrovascular occlusion

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Surgical amputation - mid thigh left

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 4/11/1967

Place of Burial or Cremation Holy Cross (City or Town) Malden

DATE OF BURIAL April 14 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed APR 12 1967 19.....

John Allen (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 69 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Machine Operator (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 021-09-5651

16 BIRTHPLACE (City) (State or country): Italy

PARENTS

17 NAME OF FATHER: Sylvester Ranalli

18 BIRTHPLACE OF FATHER (City) (State or country): Italy

19 MAIDEN NAME OF MOTHER: Anna DiBacco

20 BIRTHPLACE OF MOTHER (City) (State or country): Italy

21 Informant: Rose Cameron
(Address) 141 Meridian St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 4/12/67 (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 90

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

INSTRUCTIONS FOR MEDICAL CERTIFICATE

2 FULL NAME Winifred J. Shea (Hedderman) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 120 Yeaman St. Revere, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 40 years ..... months ..... days.

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4 (Month) 14 (Day) 67 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/17, 19 1965, to 4-14, 19 67

I last saw her alive on 4/14, 19 67, death is said to have occurred on the date stated above, at 4 05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hr

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertension

Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify no

(Signature) Salvatore A. De Luca, M. D.
Salvatore A. De Luca (Print or Type Name)

(Address) 550 Park Ave Revere Date 4/14 1967

6 Holy Cross Cemetery Malden, Mass. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL April 18, 1967 19

7 NAME OF FUNERAL DIRECTOR William J. Killion

ADDRESS 1 Sprague Street Revere, Mass.

Received and filed 19

John [illegible] APR 17 1967 (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Daniel Shea (Husband's name in full)

12 AGE 78 Years 6 Months 18 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER William Hedderman

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Hanora Finn

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Winifred (Shea) Jacob

(Address) 60 Ocean View Rd, Swampscott

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Phelip G. Vitagliano (Signature of Agent of Board of Health or other)

Dir of Pub Health (Official Designation) 4/17/66 (Date of Issue of Permit)

1M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

...d for burial permit ...Board of Health ... its Agent.

...STRUCTIONS FOR ...IAL CERTIFICATE

...RIT OR TYPE ...S OR CAUSES ... DEATH

...not enter ...e than one ...ase for each ..., (b) and (c)

...does not mean ...de of dying, ... heart failure, ...en etc. It means ...ease, or compli... which caused ...h.

...ions, if any, ...gave rise to ...cause (a), ...the under... cause last.

...ditions contrib... death but not ...o the terminal ...condition given ...a)

Medical examiner notified — referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 91

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 56 Townsend Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Beatrice Matilda Lee (Benner) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 56 Townsend Street St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death 15 years ... months ... days. In place of residence 15 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 8:30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? ...

What test confirmed diagnosis? ...

5 Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date 4/19/1967

6 Glenwood Cemetery, Everett, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 20, 1967 19...

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 20 1967 19...

John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of ... (Give maiden name of wife in full) (or) WIFE of Wallace C. Lee (Husband's name in full)

12 AGE 78 Years 11 Months 20 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation retired Secretary (Kind of work done during most of working life)

14 Industry or Business Chemical Co.

15 Social Security No. 011-01-2451-A

16 BIRTHPLACE (City) (State or country) Everett Massachusetts

PARENTS

17 NAME OF FATHER Morrill Temple Benner

18 BIRTHPLACE OF FATHER (City) (State or country) Maine

19 MAIDEN NAME OF MOTHER Emma W. Witham

20 BIRTHPLACE OF MOTHER (City) (State or country) Portsmouth New Hampshire

21 Informant Mr. Wallace C. Lee

(Address) 56 Townsend St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B) (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) 4/20/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

-9-3-936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 92

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP, MASS (City or Town); WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)
No. ..... St.

PHYSICIAN — IMPORTANT

2 FULL NAME: BESSIE KANEGIS (WEINER)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 25 SEA FOAM AVENUE St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April, 1967, to April 19, 1967
I last saw he alive on April 19, 1967, death is said to have occurred on the date stated above, at 5:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Coronary Occlusion	1 Hour
Due To (b) Hypertensive Arteriosclerotic	6 yrs.
Due To (c) Heart Disease	
OTHER SIGNIFICANT CONDITIONS Bronchial Asthma.	3 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 4/19/1967

6 Place of Burial or Cremation: AMERICAN FRIENDSHIP (City or Town) West Roxbury
DATE OF BURIAL April 21 1967

7 NAME OF FUNERAL DIRECTOR: TORF Funeral Service
ADDRESS 151 Washington Ave Chelsea

Received and filed APR 21 1967 19
John B Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEM
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of MORRIS KANEGIS
(Husband's name in full)

12 AGE 71 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER: SAMUEL WEINER

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER: BELLA TOBE

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MRS IRVING STEINBERG
(Address) 25 Sea Foam Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir of Public Health 4/21/67
(Official Designation) (Date of Issue of Permit)

M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

APR 21 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP MASS.

FORM R-301

d for burial permit
oard of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

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, etc. It means
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Conditions contrib-
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is condition given
a)

2-933404

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 83

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Harriet E (Osgood) Turner
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 2 Undine Ave. St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 3 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 23, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept., 1966, to April 23, 1967.
I last saw he alive on April 21, 1967, death is said to have occurred on the date stated above, at 1:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cancer Cervix Uterus	8 mos
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Hypertension	2 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical, surgical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 4/24/ 19 67

6 Place of Burial or Cremation: Winthrop (City or Town)
DATE OF BURIAL: April 25 19 67

7 NAME OF FUNERAL DIRECTOR: Howard S Reynolds
ADDRESS: Winthrop Mass.

Received and filed APR 25 1967 19
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Leroy Turner
(Husband's name in full)

12 AGE 76 Years 8 Months 15 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. 013-07-4121

16 BIRTHPLACE (City) Hope Island
(State or country) Maine

PARENTS

17 NAME OF FATHER: Joshia Osgood

18 BIRTHPLACE OF FATHER (City) Fryeburg
(State or country) Maine

19 MAIDEN NAME OF MOTHER: Isa Pingrey

20 BIRTHPLACE OF MOTHER (City) Denmark
(State or country) Maine

21 Informant: Willard Turner
(Address) 69 Johnson Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano
(Signature of Agent of Board of Health or other)
Dir of Public Health 4/24/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, h as heart failure, henia, etc. It means e disease, or compli- tions which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 94

I PLACE OF DEATH SUFFOLK (County)
WINTHROP (City or Town)
No. VIKING NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ROSANNA E QUEENAN (MULLEN)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 75 WOODSIDE AVE St. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 4 years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 1956, 19..., to APRIL 26, 1967
I last saw her alive on APRIL 25, 1967, death is said to have occurred on the date stated above, at 10:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CORONARY THROMBOSIS	
Due To (b) HYPERTENSION	11 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS PARKINSONS DISEASE	10 YRS

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Francis P. Schraffa, M. D.
FRANCIS P. SCHRAFFA
(Print or Type Name)
(Address) 104 BENN ST. E. BOSTON Date APR 26 1967

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL APRIL 29 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP MASS

Received and filed MAY 1 - 1967 19...
John A Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE
9 COLOR WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) WIDOWED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of JOHN P QUEENAN
(Husband's name in full)

12 AGE 86 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOME MAKER.
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. 021-07-8579

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER JOHN P MULLEN

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER SARAH LOGUE

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant JOHN QUEENAN
(Address) 390 PARK ST WEST ROX.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vetagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health 4/27/67
(Official Designation) (Date of Issue of Permit)

1-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE CUSE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

his does not mean mode of dying, ch as heart failure, enia, etc. It means disease, or compli- ions which caused th.

onditions, if any, hich gave rise to bove cause (a), ating the under- ying cause last.

Conditions contrib- ing to death but not lated to the terminal isease condition given in a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 95

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anne Gordon
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 1267 Tremont St. Roxbury, Mass.
(City or town and State)

Length of stay: In place of death 17 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL (Month) 27, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1950, to April 27, 1967
I last saw he alive on April 27, 1967, death is said to have occurred on the date stated above, at 5:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Acute Coronary Occlusion — 1 hour
Due To (b) Hypertensive Arteriosclerotic — 5 yrs.
Due To (c) Heart Disease

This does not mean the mode of dying, such as heart failure, anemia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

OTHER SIGNIFICANT CONDITIONS None.

Conditions contributing to death but not related to the terminal disease condition given in a).

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 4/27/ 19 67

6 Hand In Hand West Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 28 19 67

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home Inc
ADDRESS 420 Harvard St Brookline Mass

Received and filed APR 27 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 86 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housekeeper
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) London (State or country) England

PARENTS

17 NAME OF FATHER Simeon Gordon

18 BIRTHPLACE OF FATHER (City) London (State or country) England

19 MAIDEN NAME OF MOTHER Rachel Hart

20 BIRTHPLACE OF MOTHER (City) London (State or country) England

21 Informant Mrs. Hyman Housman Niece
(Address) 19 Wave Way Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Nitogliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 4/27/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Revere (City or Town making this return)

Registered No. 96

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town)

No. Revere Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Vincent Beatrice (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence: No. 169 Herman St. Winthrop (City or town and State)

Length of stay: In place of death ..... years ..... months 29 days. In place of residence 7 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 20, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1967, to April 20, 1967

I last saw him alive on April 20, 1967, death is said to have occurred on the date stated above, at 12:55A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Carcinoma of Prostate	4yrs.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hiatus Hernia	6yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Joseph J. Palermo, M. D.

(Address) 20 Crescent Ave. Revere Date 4/21 1967

6 St. Paul's Hingham
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 141 Winthrop St., Winthrop

Received and filed MAY 17 1967 19

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Fiorentina Ciampa (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 89 Years 11 Months 13 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Stonemason (Kind of work done during most of working life)

14 Industry or Business: Contractor

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Sabato Beatrice

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Josephine Barletto

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Sylvia Pace

(Address) 169 Herman St., Winthrop

A TRUE COPY

ATTEST: Joseph F. Whitehead
(Registrar of City or Town where death occurred)

DATE FILED April 24, 1967

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: Essex (County) — Lynn (City or Town) — Lynn (City or Town making this return)

Registered No. 97

No. Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph Burns (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, WWI

(a) Residence. No. 58 Beacon St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 15 days. In place of residence 10 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/3 1963 to 4/20 1967

I last saw him alive on 4/20 1967 death is said to have occurred on the date stated above, at 2 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Broncho pneumonia	wks
Due To (b) Obstructive emphysema	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no

What test confirmed diagnosis? xray & clinical state

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) A. L. Michelson M. D.

(Address) 139 Broad St. Lynn, Mass. Date 4/20 1967

6 Winthrop Cem. Winthrop (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL April 22, 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS 180 Winthrop St. Winthrop

Received and filed MAY 15 1967 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) married

10a If married, widowed or divorced HUSBAND of Alice E. Budreau (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 1 Months 17 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Shipping Clerk (Kind of work done during most of working life)

14 Industry or Business: G. E. Co.

15 Social Security No. 027-07-8840

16 BIRTHPLACE (City) (State or country) Newton, Mass.

PARENTS

17 NAME OF FATHER Edwin R. Burns

18 BIRTHPLACE OF FATHER (City) (State or country) c/n/b/l

19 MAIDEN NAME OF MOTHER Frances Kindred

20 BIRTHPLACE OF MOTHER (City) (State or country) c/n/b/l

21 Informant Mrs. Alice Burns

(Address) 58 Beacon Street Winthrop

A TRUE COPY

ATTEST: Albert L. Glynn (Registrar of City or Town where death occurred)

DATE FILED 4/25 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

MAY 15 '67 A

WINTHROP, MASS

FORM R-301

for burial permit
oard of Health
its Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
the terminal
ndition given

Medical Examiner's Office - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 98

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 36 Bellevue Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie Florence Binney (Rowe)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 36 Bellevue Avenue St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 25 years ..... months ..... days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 11:10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Lieberman Md

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Charles Lieberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 5/21 1967

6 Mount Auburn Cemetery, Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 4, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass

Received and filed MAY 4 - 1967 19.....

John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Edward Smith Binney
(Husband's name in full)

12 AGE 76 Years 1 Months 25 Days

If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. .....

16 BIRTHPLACE (City) Springhill
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Eli Rowe

18 BIRTHPLACE OF FATHER (City) Plymouth
(State or country) England

19 MAIDEN NAME OF MOTHER Mary Ann Cranford

20 BIRTHPLACE OF MOTHER (City) New Harbor
(State or country) Newfoundland

21 Informant Walter E. Rowe

(Address) 752 Main St. Lynnfield Ctr. Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (6)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 5/4/67
(Official Designation) (Date of Issue of Permit)

9--936348

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

: filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or complications which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not lated to the terminal sease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 99

1 PLACE OF DEATH
(County) Suffolk
(City or Town) Winthrop
No. 142 Pleasant St (Viking Nurs. Home) St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Anna Walsh (Hingley)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 12 Pico Ave St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ....years 3 months ....days. In place of residence 3 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 2 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from DEC 2, 1966, to MAY 2, 1967
I last saw him alive on MAY 2, 1967, death is said to have occurred on the date stated above, at 7:40 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) ACUTE MYOCARDIAL INFARCT — 2 DAYS
Due To (b) ARTERIO SCLEROTIC HEART DIS — 2 YRS
Due To (c) C CONGESTIVE FAILURE

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP Date 5/2 1967

6 Place of Burial or Cremation Old Calvary Boston (City or Town)
DATE OF BURIAL May 3 1967

7 NAME OF FUNERAL DIRECTOR John H. Sawyer
ADDRESS 329 Bunker Hill St. Charlestown

Received and filed MAY 2 - 1967 19..
John Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Walter Walsh
(Husband's name in full)

12 AGE 78 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation At Home
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Waybnd Mass.
(State or country)

PARENTS

17 NAME OF FATHER Simpson Hingley

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) UNKNOWN
(State or country)

21 Informant Mary Bowers
(Address) 12 Pico Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 5/2/67
(Official Designation) (Date of Issue of Permit)

M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ed for burial permit
t Board of Health
r its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

RIT OR TYPE
UE OR CAUSES
F DEATH

not enter
re than one
cise for each
f), (b) and (c)

does not mean
ode of dying,
s heart failure,
hea, etc. It means
ease, or compli-
io which caused
t)

ditions, if any,
oh gave rise to
ab cause (a),
tag the under-
yi cause last.

nditions contrib-
ng o death but not
ate to the terminal
ea condition given
(a

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 130

1 PLACE OF DEATH: Winthrop (County); Suffolk (City or Town)

No. 25 Fremont Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine Dorothy Ramsey (Finn) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Permanent Residence. No. 15 Buchanan Street St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 3 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1955, to May 3, 1967

I last saw her alive on May 3, 1967, death is said to have occurred on the date stated above, at 6:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) myocardial infarction	1 hour
Due To (b) arteriosclerosis	
Due To (c) arterial hypertension	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Ecg

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify No

(Signature) H B Greenfield, M. D.

H. B. Greenfield (Print or Type Name)

(Address) 447 Shirley St Winthrop Date 5-4 1967

6 Holy Sepulchre Cemetery, Coram, N.Y. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL May 8, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAY 8 1967 19

John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): divorced

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Walter Metcalf Ramsey (Husband's name in full)

12 AGE 58 Years 9 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business own home

15 Social Security No. —

16 BIRTHPLACE (City) Roxbury (State or country) Massachusetts

PARENTS

17 NAME OF FATHER William Joseph Finn

18 BIRTHPLACE OF FATHER (City) West Roxbury (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Catherine Harris

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) New Brunswick

21 Informant John W. Ramsey

(Address) 285 Grant Ave. Islip, N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

..... (Signature of Agent of Board of Health or other)

Philip G. Vitagliano (Mck) (Official Designation) (Date of Issue of Permit)

Director of public Health 5/5/67

A TRUE COPY ATTEST:

-63-936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel. etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 101

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniel J. Tierney (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) WW #1

(a) Permanent Residence. No. 283 Revere St. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 4 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 4, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4/20/, 1967, to MAY 4, 1967, I last saw him alive on MAY 4, 1967, death is said to have occurred on the date stated above, at 9:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral Hemorrhage — 15 days

Due To (b) Hypertension and — 4 yrs

Due To (c) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signature) Charles Lieberman, M. D.

CHARLES LIEBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date 5/4/ 1967

6 Place of Burial or Cremation St. Joseph's West Roxbury Mass (City or Town)

DATE OF BURIAL May 8, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed MAY 8 1967 19

John Allen (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 76 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Clerk (Kind of work done during most of working life)

14 Industry or Business: U.S. Postal Service

15 Social Security No.

16 BIRTHPLACE (City) Cambridge (State or country) Mass

PARENTS

17 NAME OF FATHER: Daniel Tierney

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER: Mary Brady

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

21 Informant: Esther P. Fulmore

(Address) 483 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 5/8/67 (Date of Issue of Permit)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... 12-12-17 .....

DATE OF DISCHARGE ..... 9-30-21 .....

RANK, RATING ..... AS Ships Cook .....

ORGANIZATION AND OUTFIT ..... U.S.N.R. .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-61-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Melrose
(City or Town making this return)

Registered No. 102

1 PLACE OF DEATH
Middlesex (County)
Melrose (City or Town)
No. Melrose-Wakefield Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Esther Marcus (Bergman)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 5 Myrtle Avenue St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ....years ....months 30 days. In place of residence 17 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 6, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10, 1934, to May 6, 1967
I last saw her alive on May 6, 1967, death is said to have occurred on the date stated above, at 8 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Myocardial Infarction	5 weeks
Due To (b)	
Due To (c) Arteriosclerotic Ht. Disease	10 yrs
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	5 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify No

(Signature) Irving Showstack, M. D.

(Address) Wakefield, Mass. Date May 7, 67

6 Winthrop Tifereth Israel Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 7, 67

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service Inc.

ADDRESS 151 Washington Avenue, Chelsea, Mass.

Received and filed JUN 12 1967 19....

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Herbert Marcus
(Husband's name in full)

12 AGE 68 Years ....Months ....Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Jacob Bergman

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country) Russia

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country) Russia

21 Informant Herbert Marcus
(Address) 5 Myrtle Avenue, Winthrop, Mass.

TRUE COPY
ATTEST: Paul J Barter
(Registrar of City or Town where death occurred)

DATE FILED May 9, 1967 19....

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JUN 12 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. [illegible]

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Carrie A (Warner) Buchanan
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 70 Thornton Park St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 2 years ... months ... days. In place of residence 26 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 8 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 1967 to MAY 8 1967
I last saw he alive on MAY 7 1967 death is said to have occurred on the date stated above, at 1:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart DISEASE

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

INTERVAL BETWEEN ONSET AND DEATH 24 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN (Print or Type Name)
(Address) WINTHROP, MASS Date 5/8/1967

6 Place of Burial or Cremation Woodlawn Crematory (City or Town) Everett
DATE OF BURIAL May 10 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed MAY 10 1967 1967
John R Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Edward C Buchanan (Husband's name in full)

12 AGE 91 Years 10 Months 16 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. 179-01-2411

16 BIRTHPLACE (City) Westhampton Twp. (State or country) New Jersey

PARENTS

17 NAME OF FATHER Frederick Warner

18 BIRTHPLACE OF FATHER (City) Unable to obtain (State or country)

19 MAIDEN NAME OF MOTHER Emma Coer

20 BIRTHPLACE OF MOTHER (City) Unable to obtain (State or country)

21 Informant Malvern Buchanan
(Address) 300 N. Euclid Ave Pasadena CAL.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health 5/10/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

00M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean he mode of dying, ich as heart failure, sthenia, etc. It means he disease, or compli-ations which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ting to death but not elated to the terminal isease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 104

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 9 Grovers Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William MacFarlane
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 9 Grovers Avenue St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN., 1962, to MAY 9, 1967

I last saw him alive on MAY 9, 1967, death is said to have occurred on the date stated above, at 1:30 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebro vascular	4 days
Due To (b)	Occlusion	
Due To (c)	Arteriosclerosis	
OTHER SIGNIFICANT CONDITIONS	Pulmonary Emphysema	5 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 5/9/ 1967

6 Cambridge Cem. Cambridge, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 12, 1967 19

7 NAME OF FUNERAL DIRECTOR A. E. Long & Son Inc.

ADDRESS 1979 Mass. Ave. Cambridge,

Received and filed MAY 11 1967 19

John D. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	white	widowed

11 If married, widowed, or divorced HUSBAND of Jessie Gillis ~~MacFarlane~~
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 79 Years 4 Months 19 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business: Lever Bros. Retired

15 Social Security No. 012-10-6555

16 BIRTHPLACE (City) (State or country) Lochee, Scotland

PARENTS

17 NAME OF FATHER William D. MacFarlane

18 BIRTHPLACE OF FATHER (City) (State or country) Scotland

19 MAIDEN NAME OF MOTHER Mary Ann MacCormack

20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant David MacFarlane
(Address) 9 Grovers Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (L)
(Signature of Agent of Board of Health or other)

Dir. of Public Health
(Official Designation)

5/10/67
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

July

FORM R-301

OUT-OF-TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 105

1 PLACE OF DEATH
Middlesex (County)
Malden (City or Town)
No. Malden Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles J Jordan (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence, No. 224 Court Rd St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 7 days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 10 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 1, 1967 to May 10, 1967
I last saw him alive on May 10 1967, death is said to have occurred on the date stated above, at 5 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Acute myocardial infarction
Due To (b)
Due To (c) Gen'l arteriosclerosis
OTHER SIGNIFICANT CONDITIONS Carcinoma prostate yes

INTERVAL BETWEEN ONSET AND DEATH 30 minutes

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Clarke Staples, M. D.
CLARKE STAPLES M.D. (Print or Type Name)
(Address) MALDEN Date 5/11/67

6 St Marys Scituate
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 13 1967

7 NAME OF FUNERAL DIRECTOR Ernest Plaggrano
ADDRESS 147 Winthrop St Winthrop

Received and filed MAY 12 1967 19..
Nathan J. Schneiderman (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 CITIZEN OF U.S. YES ☒ NO ☐
11 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed or divorced HUSBAND of Marie A Vincent
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 DATE OF BIRTH Sept 24 1882

13 AGE 84 Years 7 Months 12 Days If under 24 hours Hours Minutes

14 Usual Occupation: Retired Truck Driver
(Kind of work done during most of working life)

15 Industry or Business: E I Dupont

16 Social Security No. 028-05-1180

17 BIRTHPLACE (City) P.E.I.
(State or country) Canada

PARENTS
18 NAME OF FATHER Philip Jordain
19 BIRTHPLACE OF FATHER (City)
(State or country) Canada
20 MAIDEN NAME OF MOTHER Sarah Gallant
21 BIRTHPLACE OF MOTHER (City)
(State or country) Canada

22 Informant Agnes Doyle
(Address) 224 Court Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
John F. Logan
(Signature of Agent of Board of Health or other)
Dir. of Public Health 5/12/67
(Official Designation) 47653 (Date of Issue of Permit)

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

Note:- Chapter 137, Acts of 1954 requires Physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

100M 3-61-930213

TRUE COPY ATTEST:

Nathan J. Schneiderman

City Clerk

MAY 16 '67 AM

OFFICE OF THE TOWN CLE
WINTHROP, MASS.

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-5-64-938000

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: Essex (County) — Danvers (City or Town)

Danvers (City or Town making this return)

Registered No. 106

No. Danvers State Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Irving Wadsworth Longfellow (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 15 Thornton St St. Winthrop, Mass (City or town and State)

Length of stay: In place of death 39 years 8 months 29 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 15 (Day) 1967 (Year) Male

4 I HEREBY CERTIFY that I have investigated the death of the person above named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

April 30 16 May 15 67

Bronchopneumonia days

5 Accident, suicide, or homicide (specify) Pulmonary Emboli (Small) days

Date and hour of injury ... 19...

IF ACCIDENTAL, was injury causally related to the death? Acute Splenitis days

Where did Injury occur? Cerebral artophy with senile encephalopathy Yrs. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Aneurysm of thoracis aorta Yes (Specify type of place)

Manner of Injury Autopsy (How did injury occur?)

Nature of Injury

While at work Willard M Hausman Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased? Willard M Hausmann

If so, specify Hathorne Mass 5/15/67

(Signed) ..., M. D.

Mt. Hope Cemetery Boston

(Address) May 17,1967 Date ... 19...

7 Place of Burial or Cremation Graham Funeral Home (City or Town)

DATE OF BURIAL ... 19...

8 NAME OF FUNERAL DIRECTOR Hyde Park , Mass

ADDRESS May 18,1967

Received and filed JUN 2 1967 19...

John A Clark

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR: White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

12 If married, widowed, or divorced HUSBAND of ... (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

13 AGE 77 Years 11 Months 11 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Odd Jobs (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 027-40-3246

17 BIRTHPLACE (City) (State or country) Mount Hope Mass.

PARENTS

18 NAME OF FATHER James S Longfellow

19 BIRTHPLACE OF FATHER (City) (State or country) Maine

20 MAIDEN NAME OF MOTHER Ada M Lord

21 BIRTHPLACE OF MOTHER (City) (State or country) U.S.A.

22 Informant (Address) Helen A Ziolkowski Danvers,Mass

A TRUE COPY Daniel J. Toomey Tracy I Flagg

ATTEST: Dir. of Public Health 5/15/67 (Registrar of City or Town where death occurred)

DATE FILED ... 19...

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

ORM R-301

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
ondition given

3-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 107

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Theodore Metcalf
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 77 Harbor View Ave. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ....years....months 14 days. In place of residence 62 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1967, to May 17, 1967
I last saw him alive on May 17, 1967 death is said to have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yo
Due To (b) arteriosclerosis generalized	yo
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Parkinson's Disease	yo

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie M. D.
Joseph Gregorie
(Print or Type Name)
(Address) 194 Washington St. Winthrop Date 5-17 1967

6 Mayflower Place of Burial or Cremation Duxbury (City or Town)
DATE OF BURIAL May 20 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed MAY 18 1967 19....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced
HUSBAND of Ellen F Watson
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 88 Years 0 Months 29 Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation Inspector
(Kind of work done during most of working life)

14 Industry or Business U S Goverment

15 Social Security No. 012-20-6883

16 BIRTHPLACE (City) Brookline
(State or country) Mass.

PARENTS

17 NAME OF FATHER Theodore Metcalf

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Hannah L Sohier

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant John T Metcalf
(Address) 38 Harbor View Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip B Vitagliano (?)
(Signature of Agent of Board of Health or other)
Director, Public Health 5/18/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 108

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY (JULIAN) COHEN*
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 262 SHIRLEY ST St. WINTHROP MASSACHUSETTS
(City or town and State)

Length of stay: In place of death ....years....months....2 days. In place of residence 35 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 19, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JULY, 1956, to MAY 19, 1967
I last saw her alive on MAY 19, 1967 death is said to have occurred on the date stated above, at 8:25 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE MYOCARDIAL INFARCTION	3 DAYS
Due To (b) ARTERIO SCLEROTIC HEART DIS	3 YRS
Due To (c) HYPERTENSIVE HEART DIS.	10 YRS.
OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS	15 YRS.

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & ETCG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP MASS Date 5/19/67

Ezrath Israel of Malden Danvers
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 21 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine
ADDRESS 470 Harvard St., Brookline

Received and filed May 23, 1967
John B Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Morris Cohen
(Husband's name in full)

12 AGE 74 Years....Months....Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation House-wife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) cnbl
(State or country) Russia

PARENTS

17 NAME OF FATHER Philip Yotvitsky

18 BIRTHPLACE OF FATHER (City) cnbl
(State or country) Russia

19 MAIDEN NAME OF MOTHER Mollie (unknown)

20 BIRTHPLACE OF MOTHER (City) cnbl
(State or country) Russia

21 Informant Morris Cohen
(Address) 262 Shirley St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vutoghanian
(Signature of Agent of Board of Health or other)
Dir of Public Health 5/20/67
(Official Designation) (Date of Issue of Permit)

*Name changed when entering this country. (Ellis Island)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

his does not mean mode of dying, h as heart failure, henia, etc. It means disease, or complications which caused th.

onditions, if any, hich gave rise to bove cause (a), tating the underying cause last.

Conditions contributing to death but not ted to the terminal ase condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 109

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Maria Gioiosa
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 16 Frankfort St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death ....years....months 10 days. In place of residence 27 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 20, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 27 1967, to May 20, 1967

I last saw her alive on May 20, 1967, death is said to have occurred on the date stated above, at 11:30 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Cardiac Dilatation myocardial infarction	3 mos.
Due To (b) Carcinoma Gall Bladder Metastasis to Liver	3 mos.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Nephritis	yrs.

Was autopsy performed? No

What test confirmed diagnosis? Operation, Laboratory

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Rose F. Jannini, M. D.

Rose F. Jannini, M.D.
(Print or Type Name)

(Address) 450 Pleasant St. Winthrop, Mass. Date May 20, 67

6 St. Michael Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24 1967

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., E. Boston, Mass.

Received and filed May 24, 1967

John A. Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Antonio Gioiosa
(Husband's name in full)

12 AGE 79 Years....Months....Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Michael Ruggiero

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Rose Bruno

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Rose Gioiosa (daughter)
(Address) 16 Frankfort St., E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip B. Vitagliano, Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation)

5/23/67
(Date of Issue of Permit)

Tenn-6-12-6
-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

led for burial permit
Board of Health
or its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

RIT OR TYPE
E OR CAUSES
F DEATH

not enter
re than one
cise for each
), (b) and (c)

*h does not mean
ode of dying,
s heart failure,
ea, etc. It means
ease, or compli-
on which caused
th*

*ditions, if any,
hs gave rise to
be cause (a),
ta g the under-
yi cause last.*

*nditions contrib-
g death but not
te to the terminal
as condition given
(a*

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 110

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 49 Atlantic Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Irene Marsters Strang (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 49 Atlantic Street St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death 42 years ..... months ..... days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3-18, 1959, to May 21, 1967

I last saw her alive on May 19, 1967, death is said to have occurred on the date stated above, at 7.16 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: year

Due To (b) arteriosclerosis generalized — yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS Vascular occlusion both feet

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph Gregorie, M. D.
194 Wash. Joseph GREGORIE
(Print or Type Name)
(Address) 194 Washington Ave Date 5-23 1967

6 Woodlawn Cemetery Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed May 24, 1967

John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of James Harold Strang (Husband's name in full)

12 AGE 80 Years 8 Months 15 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housewife (Kind of work done during most of working life)

14 Industry or Business own home

15 Social Security No. 014-22-5000

16 BIRTHPLACE (City) East Boston (State or country) Massachusetts

PARENTS

17 NAME OF FATHER George E. Marsters

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Eliza Ann Hurley

20 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

21 Informant Gordon H. Strang

(Address) 49 Atlantic Street

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health 5/24/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

-953-936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

Be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 111

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town); WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

No. ..... St.

PHYSICIAN — IMPORTANT

2 FULL NAME VIOLA (GIRARDIN) DAVIS
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 962 SHIRLEY St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 23, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY 16, 1967, to MAY 23, 1967. I last saw he alive on MAY 23, 1967, death is said to have occurred on the date stated above, at 1:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Congestive Cardiac Failure	1 Month
Due (b) Arteriosclerotic Heart Dis	3 Yrs
Due To (c) Arteriosclerosis	5 YRS
OTHER SIGNIFICANT CONDITIONS: None	

Was autopsy performed? NO
What test confirmed diagnosis? Physical Findings

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) John F. Collins, M. D.
John F. Collins MD
(Print or Type Name)
(Address) 27 Benning Revere - MASS Date 23 May 1967

6 Place of Burial or Cremation: WINTHROP (City or Town): WINTHROP

DATE OF BURIAL MAY 26 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed MAY 25 1967 19..

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of JOHN A DAVIS
(Husband's name in full)

12 AGE 68 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No.

16 BIRTHPLACE (City) WORCESTER (State or country) MASS

PARENTS

17 NAME OF FATHER CHARLES GIRARDIN.

18 BIRTHPLACE OF FATHER (City) MANATOBA (State or country) CANADA.

19 MAIDEN NAME OF MOTHER STEPHANIE RANDEAU

20 BIRTHPLACE OF MOTHER (City) (State or country) CANADA

21 Informant JOHN A DAVIS
(Address) 962 SHIRLEY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health 5/25/67
(Official Designation) (Date of Issue of Permit)

00M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

:M R-303

ed for burial permit
Board of Health
r its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT ON THE LINE CAUSE OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93634B

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 110

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 56 Moore St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sadie (First Name) Arvedon (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 56 Moore St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 21 years ..... months ..... days. In place of residence 21 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 28 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

INCARCERATED EPIGASTRIC HERNIA. ACUTE INTESTINAL OBSTRUCTION

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M. D.
(Print or Type Name)

(Address) Boston Date 5/28 19 67

7 Place of Burial or Cremation. Pride Of Boston Woburn (City or Town)

DATE OF BURIAL May 30 19 67

8 NAME OF FUNERAL DIRECTOR Morris W. Brezniak

ADDRESS 470 Harvard St. Brookline

Received and filed John Allen MAY 29 1967 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Samuel Arvedon
(Husband's name in full)

13 AGE 72 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. .....

17 BIRTHPLACE (City) Russia (State or country)

PARENTS

18 NAME OF FATHER Unknown

19 BIRTHPLACE OF FATHER (City) Russia (State or country)

20 MAIDEN NAME OF MOTHER Unknown

21 BIRTHPLACE OF MOTHER (City) Russia (State or country)

22 Informant Mrs. Agusta Arvedon
(Address) 11 Carol Ave. Brighton, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione
(Signature of Agent of Board of Health or other)

Dir of Public Health 5/29/67
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

I be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

MEDICAL EXAMINER DECLINED JURISDICTION

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTRHOP
(City or Town making this return)

Registered No. 11[illegible]

1 PLACE OF DEATH: SUFFOLK (County); WINTRHOP MASS (City or Town)

No. WINTHROP. COMMUNITY HOSP. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MRS. ~~XXXX~~ FANNIE BAER (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 81 UPLAND RD. St. WINTRHOP. MASS (City or town and State)

Length of stay: In place of death ..... years ..... months hrs days. In place of residence 11 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 5/29/67 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 5:30 PM 5/29/67 19..., to 6:45 PM 5/29 19 67

I last saw her alive on MAY 29 19 67, death is said to have occurred on the date stated above, at 6:45 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIOSCLEROTIC HEART DIS	5 YRS
Due To (b) C ACUTE CARDIAC ASTHMA	2 HRS
Due To (c) SUPERIMPOSED ON CHRONIC EMGESTIVE FAILURE	5 YRS
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron N. King, M. D.

MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. WINTHROP MASS Date MAY 29 1967

6 WOBURN COMMUNITY CENTER - WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 30 1967

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 1505 Blue Hill Ave MATTAPAN

Received and filed MAY 31 1967 19

John R Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of MR. ABRAHAM BAER (Husband's name in full)

12 AGE 77 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER MORRIS FEINBERG

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER BESSIE (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant HAROLD FRANK

(Address) 75 UPLAND Rd. WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B.)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 5/30/67
(Official Designation) (Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MAY 31 '67

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical Examiner Waived → Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 114

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 181 Bartlett Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARIO CONTI
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 181 Bartlett Road St.
(City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 7:45 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably due
Due To (b) to natural causes.
Due To (c) Winthrop Board of Health
OTHER SIGNIFICANT CONDITIONS Charles Lieberman MD

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 5/30/ 1967

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 2 19 67

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed JUN 2 1967 19...
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Nunzia Mollica
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 76 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation Retired Merchant
(Kind of work done during most of working life)

14 Industry or Business: Fruit & Produce

15 Social Security No. 034-24-4589 A

16 BIRTHPLACE (City) Sicily
(State or country) Italy

PARENTS

17 NAME OF FATHER Angelo Conti

18 BIRTHPLACE OF FATHER (City) Sicily
(State or country) Italy

19 MAIDEN NAME OF MOTHER Agatha Lazzara

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

21 Informant Mario Conti
(Address) 181 Bartlett Road

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 6/1/67
(Official Designation) (Date of Issue of Permit)

DOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Reported to Med. Examiner. - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 115

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
CLIFF HOUSE NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNA (LUSH) HAWKINS (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 202 Washington Avenue xx Chelsea, Mass. (City or town and State)

Length of stay: In place of death 4 years ... months ... days. In place of residence 4 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 31 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 11:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably due
Due To (b) to natural causes.
Due To (c) Winthrop Board of Health
OTHER SIGNIFICANT CONDITIONS Charles Lieberman MD

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 5/31/ 19 67

6 Place of Burial or Cremation Glenwood Cemetery Everett, Mass (City or Town)
DATE OF BURIAL JUNE 2 19 67

7 NAME OF FUNERAL DIRECTOR W. R. CARAFA
ADDRESS 389 WASHINGTON AVE CHELSEA

Received and filed JUN 2 1967 19...
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F
9 COLOR W
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

11 If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of Selby HAWKINS (Husband's name in full)

12 AGE 86 Years 5 Months 21 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: —

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) N.F.L'd CANADA

PARENTS
17 NAME OF FATHER William Lush
18 BIRTHPLACE OF FATHER (City) (State or country) N.F.L'd CANADA
19 MAIDEN NAME OF MOTHER McHugh
20 BIRTHPLACE OF MOTHER (City) (State or country) N.F.L'd CANADA

21 Informant Selby HAWKINS
(Address) 14 FAIRFAX ST. WALTHAM MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione
(Signature of Agent of Board of Health or other)
Dir of Public Health 6/2/67
(Official Designation) (Date of Issue of Permit)

Chelsea - 6-2-67
DOM-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons),thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

116

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 62927

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town) — No. DEPT. OF HEALTH & HOSPITALS St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ALEXANDER (~~XXXXXXXX~~) McGillivray (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 170 Cliff Ave. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 22, 1967 (Month) (Day) (Year)

WE HEREBY CERTIFY, That WE attended deceased from March 11, 1967, to March 22, 1967, WE last saw him alive on March 22, 1967, death is said to have occurred on the date stated above, at 12:10 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory and Cardiac Arrest — Min.

Due To (b) Anoxia — Hrs.

Due To (c) Lobar Pneumonia, Septicemia — Hrs. Days

OTHER SIGNIFICANT CONDITIONS: Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles Averill, M. D.
Charles Averill M.D. Exec. Asst.
(Print or Type Name)

(Address) DEPT. OF HEALTH & HOSPITALS Date 3-22-67

6 Place of Burial or Cremation: New Calvary (City or Town) Boston

DATE OF BURIAL March 25 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. MacRath

ADDRESS East Boston

Received and filed ..... 19..... (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male — 9 COLOR: white — 10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed or divorced HUSBAND of STELLA LOCKE (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 83 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Pipe Fitter (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 011-03-2721

16 BIRTHPLACE (City or Town) (State or country) Prince Edward Island

PARENTS

17 NAME OF FATHER: UNKNOWN

18 BIRTHPLACE OF FATHER (City) (State or country): P.E.I.

19 MAIDEN NAME OF MOTHER: UNKNOWN

20 BIRTHPLACE OF MOTHER (City) (State or country): P.E.I.

21 Informant: Anselm C. McLean
(Address) 412 Granite Ave. Milton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) — (Official Designation) — (Date of Issue of Permit) Mar. 24, 1967

H90
H89

Attest:

William J. Kane.

City Registrar

JUN 22 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

163
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X71

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

117 (City or Town making this return)

Registered No. 63239

1 PLACE OF DEATH: SUFFOLK (County) — OUT OF TOWN
BOSTON (City or Town)
No. U.S. PUBLIC HEALTH SERV. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: FRANCIS McDONALD (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW#1 & 2

(a) Permanent Residence. No. 106 BARTLETT Rd. St. WINTHROP MASS (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 31 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 31, 1967, to March 31, 1967
I last saw him alive on March 31, 1967 death is said to have occurred on the date stated above, at 12 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CONGESTIVE HEART FAILURE	24 hrs.
Due To (b) METASTATIC CARCINOMA	2 yrs
Due To (c) LUNG CANCER	2 1/2 yrs
OTHER SIGNIFICANT CONDITIONS: BRAIN ABCESS	2 1/2 yrs.

Was autopsy performed? yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signature) Aaron W. Kemper, M. D.
Aaron W. Kemper (Print or Type Name)
(Address) USPHS Hosp. Boston Date April 1 1967

6 Arlington National Arlington Wa.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 4, 1967

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley
ADDRESS: Winthrop, Mass

Received and filed APR 5 1967
[signature] (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Gertrude L. Meleedy (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 67 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired U.S.C.G. (Kind of work done during most of working life)

14 Industry or Business: U.S.C.G.

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country): Boston, Mass

PARENTS

17 NAME OF FATHER: John McDonald

18 BIRTHPLACE OF FATHER (City) (State or country): Ireland

19 MAIDEN NAME OF MOTHER: Mary Bourke

20 BIRTHPLACE OF MOTHER (City) (State or country): England

21 Informant: Gertrude McDonald
(Address) 106 Bartlett Road Winthrop, M

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[signature] E 07686
(Signature of Agent of Board of Health or other)
(Official Designation) April 3, 1967 (Date of Issue of Permit)

DOM-5-64-938000

A TRUE COPY ATTEST

JUN 26 '67 A

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

444
84

Funeral Director: Please use only BLACK ink.

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

119 (City or Town making this return)

Registered No. 63303

No. Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ~~Anna~~ Antonetta REGGIONE (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 4 Johnson ave. St. Winthrop Mass (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4 - 3 - 67 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3-31, 1967, to 4-3-, 1967

I last saw her alive on 4-3-67, 19..., death is said to have occurred on the date stated above, at 3:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Intracerebral hemorrhage

Due To (b)

Due To (c) Essential hypertension

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 3 days

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 4-3- 1967

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 6 1967

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 7 1967 19...

[signature] (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Domenic Reggione (Husband's name in full)

12 AGE 64 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Joseph Brogna

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Emanuella Capobianco

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Emanuella Gurliaccio (daughter)

(Address) 4 Johnson Ave., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature] E 07789
(Signature of Agent of Board of Health or other)

(Official Designation) April 5 1967 (Date of Issue of Permit)

M-8-66-943275

A TRUE COPY ATTEST:

William J. Kane

City Recorder

JUN 26 '67

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

162.1
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

119 (City or Town making this return)

Registered No. 63361

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles J. BURKE (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WWII

(a) Permanent Residence. No. 80 Washington St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 23 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That VA attended deceased from March 13 19 67, to April 5, 19 67 xxxxxxxxxxxxx xx, death is said to have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Aspiration secondary to small bowel obstruction (volvulus at ligament of trites)(acute gangrene entire jejunum and ileum)

INTERVAL BETWEEN ONSET AND DEATH hrs.

Due To (b) ~~///~~

Due To (c)

OTHER SIGNIFICANT CONDITIONS Carcinoma left main stem bronchus with local metastasis (mos)

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signature) William Johnson Jr., M. D.

William Johnson, Jr. (Print or Type Name)

(Address) VAH, Boston, Mass Date Apr 6 19 67

6 Winthrop Cem., Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 8 19 67

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed APR 10 1967 19

William J. Keane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Divorced

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

12 AGE 67 Years 7 Months 12 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Bookkeeper (Retired) (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 023 05 0559

16 BIRTHPLACE (City) Medford (State or country) Mass.

PARENTS

17 NAME OF FATHER Thomas F. Burke

18 BIRTHPLACE OF FATHER (City) Springfield, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Alicia Mann

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant V. A. Hospital Records 150 So. Huntington Ave. (Address) Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. J. Kasnecki (Signature of Agent of Board of Health or other)

EC 7/845 (Official Designation) 4/6/67 (Date of Issue of Permit)

DOM-9-65-941327

A TRUE COPY ATTEST:

William J. Kane.

Deed Registrar

JUN 26 '67 AM

THE TOWN CL

WINTHROP, MASS.

OUT OF TOWN

FORM R-303

be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

90 141 X72

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return) 120

Registered No.

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town) Massachusetts General Hospital

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME LEWIS COHEN
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 109 Shore Drive, St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years ....months ....days. In place of residence 35 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 6, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Fracture of skull. Bilateral subdural hematomas.

5 Accident, suicide, or homicide (specify) Accident.
Date and hour of injury April 6, 19 67
IF ACCIDENTAL, was injury causally related to the death? Yes.
Where did Injury occur? Revere, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Industrial building. (Specify type of place)
Manner of Injury Fall from ladder. (How did injury occur?)
Nature of Injury
While at work? ....Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased? ....
If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 4/7 19 67

7 Place of Burial or Cremation. MERITZ CEMETERY WOBURN (City or Town)
DATE OF BURIAL APRIL 7-1967 19

8 NAME OF FUNERAL DIRECTOR Solomon Funeral Home
ADDRESS 420 Harvard St Brookline

Received and filed APR 1 1967 19
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: MALE
10 COLOR: WHITE
11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

12 If married, widowed, or divorced HUSBAND of BELLE GERSTEIN
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

13 AGE 78 Years ....Months ....Days. If under 24 hours ....Hours ....Minutes

14 Usual Occupation: SALESMAN
(Kind of work done during most of working life)

15 Industry or Business: ELECTRICAL SUPPLY

16 Social Security No.

17 BIRTHPLACE (City) NEW YORK CITY
(State or country) NEW YORK

PARENTS

18 NAME OF FATHER WOLFE COHEN

19 BIRTHPLACE OF FATHER (City) ....
(State or country) ENGLAND

20 MAIDEN NAME OF MOTHER LIBBY UNKNOWN

21 BIRTHPLACE OF MOTHER (City) ....
(State or country) ENGLAND

22 Informant IRVING COHEN (SON)
(Address) 20 LEWIS AVE WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Eugene Leonard E 07869
(Signature of Agent of Board of Health or other)
(Official Designation) April 7 1967 (Date of Issue of Permit)

OFFICIAL

A TRUE COPY ATTEST:

William J. Lowe

City Registrar

JUN 25 '67

UT = OF = TOWN OUT - OF - TOWN

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or compli- tions which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ing to death but not loted to the terminal sease condition given (a).

332
70

neral Director: Please use only BLACK Ink.

M-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

121
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 68502

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Agnes Smith (Reynolds) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 84 Viking Gardens, Winthrop, Mass. St. (City or town and State)

Length of stay: In place of death ..... years ..... months 20 days. In place of residence 1 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 9,1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That attended deceased from 3/27/67, 19..., to April 9,1967, 19..., last saw her alive on April 9,1967, 19..., death is said to have occurred on the date stated above, at 12/35 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Infarction	Days
Due To (b) Cerebral Thrombosis	Days
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Multiple Pulmonary Emboli	Weeks

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 4/9/67 19

6 Green Lown Cem. Nahant Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Wed 12, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St Winthrop

Received and filed APR 13 1967

A TRUE COPY ATTEST: [signature] J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Howard Joseph Smith (Husband's name in full)

12 AGE 81 Years — Months — Days | If under 24 hours Hours Minutes

13 Usual Occupation Stenographer (Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. 015-20-0962

16 BIRTHPLACE (City) (State or country) Brookline MASS

PARENTS

17 NAME OF FATHER James F Reynolds

18 BIRTHPLACE OF FATHER (City) (State or country) IRLAND

19 MAIDEN NAME OF MOTHER not known

20 BIRTHPLACE OF MOTHER (City) (State or country) IRLAND

21 Informant Howard Smith

(Address) 84 Viking Gardens Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Robert J. Garnicks
(Signature of Agent of Board of Health or other)

E07996 (Official Designation) 4/10/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane

AUG 27 '07 AM

FORM R-301

be filed for burial permit with Board of Health or its Agent

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

122
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. [illegible]

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

xx Veterans Administration Hospital xx (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Louis F. Lambert (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WWII

(a) Permanent Residence. No. 21 Paine St. Winthrop, Mass. (City or town and State)

Length of stay In place of death ..... years ..... months 14 days. In place of residence 30 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I VA attended deceased from Mar. 31, 1967, to Apr. 14, 1967 xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx, death is said to have occurred on the date stated above, at 12:30P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Gastrointestinal hemorrhage secondary to esophageal varices	days
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Acute pancreatitis (days) Severe fatty nutritional cirrhosis	yrs.

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signature) Ray J. Pensinger, M. D.

Ray J. Pensinger (Print or Type Name)

(Address) VAH, Boston, Mass. Date Apr. 14 1967

6 Winthrop Cem., Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 17 1967

7 NAME OF FUNERAL DIRECTOR XXXX Maurice Kirby

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed APR 18 1967 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Annette Bradley (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 51 Years 9 Months 21 Days — If under 24 hours Hours Minutes

13 Usual Occupation maintance (Kind of work done during most of working life)

14 Industry or Business: not known

15 Social Security No 015-18-5189

16 BIRTHPLACE (City) Winthrop (State or country) Mass.

PARENTS

17 NAME OF FATHER Peter Lambert

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Roe

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant V. A. Hospital Records, 150 S. (Address) Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

E08206 Apr 16, 1967

(Official Designation) (Date of Issue of Permit)

581
105

M-8-66-943275

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

JUN 23 '67 AM

TOWN CLERK

MASS

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

+20.1
81
+70

Funeral Directors Please use only BLACK Ink.

00M-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 128

Registered No. 000-67

1 PLACE OF DEATH: SUFFOLK (County) — BOSTON (City or Town) — No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Massachusetts General Hospital BAKER MEMORIAL

PHYSICIAN — IMPORTANT

2 FULL NAME: Goly Yen (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W.I.

(a) Permanent Residence. No. 476 Shirley Street, St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April 18, 1967 (Month) (Day) (Year)

I (we) HEREBY CERTIFY, That I (we) attended deceased from April 17, 1967, to April 18, 1967. I (we) last saw alive on April 18, 1967, death is said to have occurred on the date stated above, at 6.20a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute myocardial infarction	2 days
Due To (b) Coronary artery disease	unknown
Due To (c)	years
OTHER SIGNIFICANT CONDITIONS: Diabetes mellitus	4 years

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Charles L. Clay, M. D. (Print or Type Name), M. D.

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 4/18/67, 19..

6 Place of Burial or Cremation: Forest Hills Cem. Boston (City or Town)

DATE OF BURIAL: April 20, 1967

7 NAME OF FUNERAL DIRECTOR: Edw. F. Fitzgibbon

ADDRESS: 252 Adams St. Dorchester

Received and filed APR 24 1967, 19..

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: yellow

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed or divorced HUSBAND of: Ging Goon Hom (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE: 77 Years ..... Months ..... Days. If under 24 hours: Hours ..... Minutes

13 Usual Occupation: Prop. (Kind of work done during most of working life)

14 Industry or Business: Laundry

15 Social Security No. 0[illegible]-26-5327

16 BIRTHPLACE (City) (State or country): Vina California

PARENTS

17 NAME OF FATHER: unknown

18 BIRTHPLACE OF FATHER (City) (State or country): China

19 MAIDEN NAME OF MOTHER: unknown

20 BIRTHPLACE OF MOTHER (City) (State or country): China

21 Informant: David Yee

(Address) 182 Thorndike St. Brooklin

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) Apr 20 1967

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

JUN 23 '67 A

WINTHROP

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass.
(City or Town making this return)

Registered No. 124

1 PLACE OF DEATH
Suffolk (County)
Winthrop, Mass. (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Byron R. Wasson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 22 Buchanan St. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ....years....months 5 days. In place of residence 50 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 3 (Day) 1967 (Year)

4. I HEREBY CERTIFY That I attended deceased from May 5th, 1967, to June 3, 1967. I last saw him alive on June 3, 1967, death is said to have occurred on the date stated above, at 5:07 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hr

Due To (b) Myocardial Heart Disease — 4 yrs

Due To (c) Hypertension essential — 4 yr

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? —

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M. D.
Dr. Joseph Gregorie
(Print or Type Name)
(Address) 194 Winthrop St. Date 6-3 1967

6 Winthrop — Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 7, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 7 1967 19....

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Florence Hadley
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 60 Years ... Months ... Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation Proprietor
(Kind of work done during most of working life)

14 Industry or Business: Florist

15 Social Security No. 024-03-0486

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER Ernest E. Wasson

18 BIRTHPLACE OF FATHER (City) New Yarmouth
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Martha Hazel

20 BIRTHPLACE OF MOTHER (City) C.B.L.
(State or country)

21 Informant Byron R. Wasson Jr.
(Address) Edgehill Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip A. Vitaglione (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health — 6/7/67
(Official Designation) (Date of Issue of Permit)

C-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
IEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or complitions which caused ath.

Conditions, if any, which gave rise to abave cause (a), stating the underlying cause last.

Conditions contribing to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 125

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. 39 SEA FOAM AVENUE St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FANNIE BLOCH (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 39 SEA FOAM AVENUE St. WINTHROP (City or town and State)

Length of stay: In place of death 45 years ..... months ..... days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 15, 1962, to JUNE 6, 1967

I last saw her alive on JUNE 2 1967 death is said to have occurred on the date stated above, at 12 55 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) MYOCARDIAL INFARCTION	3°
Due To (b) ARTERIO-SCLEROTIC + HYPERTENSIVE HEART DIS	5 YRS
Due To (c) WITH CONGESTIVE FAILURE + HEART BLOCK	2 YRS
OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS	8 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING MD
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP Date 6/6 1967

6 TIFERETH ISRAEL of WINTHROP - EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 7, 1967

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON ST, BROOKLINE

Received and filed JUN 8 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of MYER BLOCH (Husband's name in full)

12 AGE 80 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER PESACH GROMAN

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER TRINA BARON

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MORRIS BLOCH

(Address) 1 WHITMAN ROAD SWAMPSCOTT

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health 6/7/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN 8 '61 A
OFFICE OF THE TOWN
WINTHROP, MA

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

126

Cambridge (City or Town making this return)

Registered No. 802

1 PLACE OF DEATH: Middlesex (County) Cambridge (City or Town)

No. Holy Ghost Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marguerite Wickwire (Dilling) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 54 Shirley St. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years 2 months 24 days. In place of residence 47 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 6, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Mar. 13, 1967 to June 6, 1967

I last saw her alive on June 6, 1967 death is said to have occurred on the date stated above, at 6:17A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To (b) Metastatic Carcinoma of Breast

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Samuel R. Gargano, M. D.

(Address) Holy Ghost Hosp. Date 6-6 1967

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 9, 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JUL 5 1967 19

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Warren A. Wickwire (Husband's name in full)

12 AGE 57 Years 11 Months 25 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Teacher (Kind of work done during most of working life)

14 Industry or Business: Kindergarden

15 Social Security No. 021-12-3267

16 BIRTHPLACE (City) Sunderland (State or country) England

PARENTS

17 NAME OF FATHER James Dilling

18 BIRTHPLACE OF FATHER (City) Aberdeen (State or country) Scotland

19 MAIDEN NAME OF MOTHER Margaret McCabe

20 BIRTHPLACE OF MOTHER (City) Aberdeen (State or country) Scotland

21 Informant William Wickwire

(Address) 54 Shirley St. Winthrop

A TRUE COPY Thomas M. McNamara

ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED June 7, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JUL 5 '67 AM

OFFICE OF THE TOWN CLERK
SOUTHBOROUGH, MASS.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

*his does not mean
mode of dying,
h as heart failure,
enia, etc. It means
disease, or compli-
ons which caused
th.*

*onditions, if any,
hich gave rise to
bove cause (a),
ating the under-
ing cause last.*

*Conditions contrib-
g to death but not
ted to the terminal
ase condition given
a).*

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 127

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Miss Amelia E. Rausch (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 110 Circuit Rd. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 37 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 7 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19.., I last saw he alive on ....., 19.., death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Coronary Occlusion	5 hrs
Due To (b) Arteriosclerosis	6 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) ....., M. D.
(Print or Type Name)
(Address) ..... Date ..... 19..

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 10 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed JUN 12 1967 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 84 Years 2 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation At home
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 033-34-4485

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Christian Rausch

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Germany

19 MAIDEN NAME OF MOTHER Amelia Rudolph

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Germany

21 Informant Willard Lutze
(Address) 110 Circuit Rd. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Mck)
(Signature of Agent of Board of Health or other)

Director of Public Health 6/9/67
(Official Designation) (Date of Issue of Permit)

8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

*his does not mean
mode of dying,
h as heart failure,
enia, etc. It means
disease, or compli-
ons which caused
th.*

*onditions, if any,
hich gave rise to
bove cause (a),
ating the under-
ing cause last.*

*Conditions contrib-
g to death but not
eted to the terminal
iase condition given
in a).*

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass.
(City or Town making this return)

Registered No. 128

1 PLACE OF DEATH: Suffolk (County)
Winthrop, Mass. (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ada Gilbert (Miller)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 103 Summit Ave. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 34 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 6, 1967, to June 9, 1967
I last saw her alive on June 9, 1967, death is said to have occurred on the date stated above, at 4:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Myxedema	2 months
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	None	

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 6/9/ 1967

6 Rab. ISAAC ELCHONAN - EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JUNE 11 1967

7 NAME OF FUNERAL DIRECTOR TORF funeral Service
ADDRESS 151 WASHINGTON Ave Chelsea

Received and filed JUN 13 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Fem
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of /
(Give maiden name of wife in full)
(or) WIFE of HYMAN GILBERT
(Husband's name in full)

12 AGE 73 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation AT Home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) WALES
(State or country) ENGLAND

PARENTS

17 NAME OF FATHER ZALMON MILLER

18 BIRTHPLACE OF FATHER (City) ENGLAND
(State or country)

19 MAIDEN NAME OF MOTHER CBC

20 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)

21 Informant HENRY S GILBERT
(Address) 12 Sheridan Rd ANDOVER

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Dir of Public Health 6/11/67
(Official Designation) (Date of Issue of Permit)

8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN
OF TH
WINTHR

ORM R-301

for burial permit
ard of Health
Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
DR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
have rise to
cause (a),
the under-
cause last.

ntions contrib-
death but not
the terminal
ndition given

2-:-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 129

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Fannie Lement
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 1343 Collins Ave St. Miami Beach Fla.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..years..months 10 days. In place of residence 2 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 14 (Day), 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April, 1966, to June 14, 1967
I last saw he alive on June 14, 1967, death is said to have occurred on the date stated above, at 2:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of colon
Due To (b) with metastases
Due To (c) to abdomen and bladder

INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Surgical, Path.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 6/14/1967

6 Workmens Circle Melrose
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 15 1967

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach
ADDRESS 1168 Beacon St. Brline

Received and filed JUN 15 1967 19..
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of ..
(Give maiden name of wife in full)
(or) WIFE of Louis Lement
(Husband's name in full)

12 AGE 78 Years..Months..Days | If under 24 hours ..Hours..Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business At Home

15 Social Security No. 033-22-8422 A

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Louis Bobrick

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Tillie Barron

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Mr Isadore Schwartz
(Address) 47 Dolphin Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitaglione (?)
(Signature of Agent of Board of Health or other)
Dir of Public Health 6/15/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
h mode of dying,
as heart failure,
senia, etc. It means
h disease, or compli-
ons which caused
h.

onditions, if any,
hich gave rise to
ove cause (a),
ating the under-
ing cause last.

Conditions contrib-
ting to death but not
ed to the terminal
ise condition given
n a).

Medical examiner notified - referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 130

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. D.A. WINTHROP Comm. Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SAMUEL BRAFF
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 43 HUTCHINSON ST. St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 15, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 6:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably

Due To (b) due to natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Lieberman, M.D

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Charles Lieberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 6/15/1967

6 BETH DAVID WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 18 1967

7 NAME OF FUNERAL DIRECTOR TORF Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed JUN 19 1967 19.....

John A. Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M

9 COLOR W

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

11 If married, widowed, or divorced HUSBAND of ROSE ROSS
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE 83 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation PROPRIETOR
(Kind of work done during most of working life)

14 Industry or Business: GROCERY STORE

15 Social Security No. 033-26-3180

16 BIRTHPLACE (City) (State or country) Austria

PARENTS

17 NAME OF FATHER ABRAHAM BRAFF

18 BIRTHPLACE OF FATHER (City) (State or country) AUSTRIA

19 MAIDEN NAME OF MOTHER ESTHER ??

20 BIRTHPLACE OF MOTHER (City) (State or country) AUSTRIA

21 Informant Marion LAUB

(Address) 49 Hutchinson St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (?)
(Signature of Agent of Board of Health or other)

Dir of Public Health June 17/67
(Official Designation) (Date of Issue of Permit)

003-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN 19
WINTHROP

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean mode of dying, as heart failure, nia, etc. It means disease, or compli- ns which caused it.

nditions, if any, ich gave rise to ove cause (a), ting the under- ng cause last.

Conditions contrib- to death but not d to the terminal se condition given).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 131

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine A, Flanagan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 45 Taft Avenue St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 12 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1967 to June 15, 1967

I last saw h alive on June 14, 1967 death is said to have occurred on the date stated above, at 4:24 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart disease	yrs
Due To (b) Arteriosclerosis gen	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Uremia	yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Goeppe, M. D.
Joseph Goeppe
(Print or Type Name)
(Address) 1 Washington Date June 15 1967

6 Oak Grove Ceme. Medford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 17, 1967 19

7 NAME OF FUNERAL DIRECTOR Joseph P. Murphy

ADDRESS 322 Bunker Hill St. Charlestown

Received and filed JUN 19 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Daniel J. Flanagan (Husband's name in full)

12 AGE 86 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation at Home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Ireland (State or country)

PARENTS

17 NAME OF FATHER Thomas Brady

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Margaret Greeley

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Helen Mc Comiskey

(Address) 10 Wall St. Charlestown

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health - 6/16/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN 19
OFFICE OF
WINTH

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS FOR
DICAL CERTIFICATE

INT OR TYPE
ISE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
the mode of dying,
as heart failure,
nia, etc. It means
disease, or compli-
ns which caused
h.

nditions, if any,
ich gave rise to
ove cause (a),
ting the under-
ng cause last.

Conditions contrib-
to death but not
d to the terminal
se condition given
).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 132

PLACE OF DEATH

1 (County) Suffolk

(City or Town) Winthrop

No. 476 Winthrop Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ursula (Pastore) DeChristoforo
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 476 Winthrop Street St. Winthrop
(City or town and State)

Length of stay: In place of death 35 years ..... months ..... days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 16, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 7:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Death presumably due

Due To (b) to natural causes.

Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Lieberman M.D.

Was autopsy performed? No

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Charles Lieberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/19/ 19 67

6 St. Michael Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 20, 19 67

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed JUN 20 1967 19.....

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Americo DeChristoforo
(Husband's name in full)

12 AGE 70 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Frank Pastore

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Julia Ressa

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Claire Christopher (daughter)

(Address) 476 Winthrop St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (?)
(Signature of Agent of Board of Health or other)

Dir. of Public Health June 19, 1967
(Official Designation) (Date of Issue of Permit)

Reported to Med Examiner - Referred to Board of Health

-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
h mode of dying,
u as heart failure,
senia, etc. It means
h disease, or compli-
ons which caused
h.

nditions, if any,
hich gave rise to
ove cause (a),
ating the under-
ing cause last.

Conditions contrib-
ut g to death but not
ed to the terminal
ise condition given
n a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 133

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Andrew Pugliese (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 15 Rockwell St. Dorchester (City or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1966, to June 17, 1967

I last saw him alive on 6-14-, 1967, death is said to have occurred on the date stated above, at 6:50 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yrs
Due To (b) Arteriosclerosis generalized	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie, M. D.

Joseph Gregorie (Print or Type Name)

(Address) 194 Washington St. Winthrop Date 6-17 1967

6 St. Michaels Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 19 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS East Boston

Received and filed JUN 19 1967 John A. Clark 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed or divorced HUSBAND of Julia Caprio (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 87 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Carpenter (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. ~~CNBL~~ 033-16-6581T

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER John Pugliese

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Olympia

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Julia Pugliese

(Address) 15 Rockwell St. Dorchester

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (h)
(Signature of Agent of Board of Health or other)

Dir of Public Health June 19, 1967
(Official Designation) (Date of Issue of Permit)

0003-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN

RM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR INK ADDRESS ... PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

TEWKSBURY HOSPITAL
(City or Town making this return)

Registered No. 111

1 PLACE OF DEATH: Middlesex (County); Tewksbury, Mass. (City or Town)

No. TEWKSBURY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Brooks (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence. No. 29 27 Washington St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 1 months 7 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 18, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 11, 1966 to June 18, 1967

I last saw her alive on June 18, 1967, death is said to have occurred on the date stated above, at 10:30a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 3 Yrs

Due To (b) Unknown

Due To (c) ------

OTHER SIGNIFICANT CONDITIONS Post Streptococcal meningitis Urinary Tract infection Mos.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Melecio H. Flores, M. D.

(Address) TEWKSBURY HOSPITAL Date 6-18- 1967

6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL 6-21- 1967

7 NAME OF FUNERAL DIRECTOR Frederick Magrath

ADDRESS 325 Chelsea St., E. Boston

Received and filed JUL 1967 19 Supt.

John A. Clark

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced HUSBAND of ------ (Give maiden name of wife in full)

(or) WIFE of ------ (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 5 Months 12 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housework (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 021-03-6986

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Emmanuel J. Brooks

18 BIRTHPLACE OF FATHER (City) cannot be learned (State or country) Portugal

19 MAIDEN NAME OF MOTHER Rosalie Matos

20 BIRTHPLACE OF MOTHER (City) cannot be learned (State or country) Portugal

21 Informant (Address) Hospital Records & Undertaker & Brother

A TRUE COPY

ATTEST: [signature] Supt.

(Registrar of City or Town where death occurred)

DATE FILED 6-18 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

ORM R-301

for burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 135

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Zetta Morrison
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 80 Wellington Road, St. Medford, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 2 years 2 months ..... days. In place of residence 2 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 21 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1965, to June 21, 1967

I last saw her alive on June 21, 1967, death is said to have occurred on the date stated above, at 4:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral haemorrhage

Due To (b) Cerebral Arteriosclerosis

Due To (c) 0

OTHER SIGNIFICANT CONDITIONS 0

INTERVAL BETWEEN ONSET AND DEATH: 2 days

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify NO

(Signature) Charles J. Ferrera, M. D.

Charles J. Ferrera
(Print or Type Name)

(Address) 154 Bennington St East Boston Date 6/21/67

New Calvary Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 24th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed JUN 22 1967 19..

John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 78 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation School Teacher-Retired
(Kind of work done during most of working life)

14 Industry or Business Boston Schools

15 Social Security No. 013-36-5938

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER John F. Morrison

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Jane T. Matthews

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Mrs. Francis D. Morrison

(Address) 80 Wellington Rd., Medford

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Div. of Public Health 6/22/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

63936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN 22 '6
ROP. M

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 136

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RUTH A. (SMITH) BELL (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 54 HIGHLAND AVE, WINTHROP St. (City or town and State)

Length of stay: In place of death ..... years ..... months 28 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE (Month) 22, (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from May, 1967, to June 22, 1967

I last saw him alive on June 22, 1967, death is said to have occurred on the date stated above, at 2:20 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yr
Due To (b) Arteriosclerosis-gen	yr
Due To (c) Senility	yrs
OTHER SIGNIFICANT CONDITIONS Cerebro-Vascular accident	2 days

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE (Print or Type Name)
(Address) 194 Washington Ave Date 6-22 1967

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)

DATE OF BURIAL June 24, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 23 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Martin J. Bell (Husband's name in full)

12 AGE 87 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. -- - -

16 BIRTHPLACE (City) (State or country) Quincy Mass

PARENTS

17 NAME OF FATHER Robert Smith

18 BIRTHPLACE OF FATHER (City) (State or country) Quincy Mass

19 MAIDEN NAME OF MOTHER Agnes Welch

20 BIRTHPLACE OF MOTHER (City) (State or country) C. B. L.

21 Informant Ruth Kenney

(Address) 54 Highland Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip L Vitagliano (s) (Signature of Agent of Board of Health or other)

Dir of Public Health 6/23/67 (Official Designation) (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-305

137

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Canton
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Norfolk (County); Canton (City or Town)

No. Blue Hill Country Club St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Felix F. Albano (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 151 Bartlett Road St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 24, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute Coronary Thrombosis

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19 .....
If accidental, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Appleton C. Woodward, M. D.
(Address) Stoughton Mass. Date 6/24 1967

7 Winthrop Cemetery Winthrop
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL June 28 1967

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS Winthrop Mass.

Received and filed JUN 29 1967 19 .....
John Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M
10 COLOR White
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of Mary E. Musco (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 58 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Rest Home Operator (Kind of work done during most of working life)

15 Industry or Business: Rest Home

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

18 NAME OF FATHER Vincent Albano

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Antonette Diesco

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant (Address) Mary E. Albano
~~151 Bartlett Road, Winthrop~~

A TRUE COPY ATTEST: Maurice E. Ronayne Jr.
(Registrar of City or Town where death occurred)

DATE FILED June 27 1967

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JAN 29 '67

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 138

1 PLACE OF DEATH: SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSP. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DANIEL P. DOHERTY (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 105 GROVERS AVE St. WINTHROP MASS (City or town and State)

Length of stay: In place of death ..... years ..... months 17 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1957, to June 24, 1967
I last saw him alive on June 24, 1967, death is said to have occurred on the date stated above, at 6:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion	17 days
Due To (b) Hypertensive - Arterio-	10 yrs.
Due To (c) Sclerotic Heart Disease	
OTHER SIGNIFICANT CONDITIONS Parkinson's	10 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 6/24 1967

6 WINTHROP (Place of Burial or Cremation) WINTHROP (City or Town)
DATE OF BURIAL JUNE 27 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP MASS

Received and filed JUN 26 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced HUSBAND of JENNEY V REED (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 76 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation NEWS PAPER (Kind of work done during most of working life)

14 Industry or Business: PLANT MAINTENANCE

15 Social Security No. 021-10-7434

16 BIRTHPLACE (City) (State or country) BOSTON MASS

PARENTS

17 NAME OF FATHER GEORGE DOHERTY

18 BIRTHPLACE OF FATHER (City) (State or country) IRELAND

19 MAIDEN NAME OF MOTHER (UNKNOWN) DEVLIN

20 BIRTHPLACE OF MOTHER (City) (State or country) IRELAND

21 Informant JENNEY V DOHERTY
(Address) 105 GROVERS AVE WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 6/26/67
(Official Designation) (Date of Issue of Permit)

1M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
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nditions contrib-
to death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 139

1 PLACE OF DEATH
SOFFOLK (County)
WINTHROP (City or Town)
No. 96 LORING RD St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ALICE F DWYER (DAILY)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 96 LORING RD St. WINTHROP MASS
(Usual place of abode) (City or town and State)

Length of stay: In place of death 53 years ..... months ..... days. In place of residence 53 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1950, to June 24, 1967
I last saw him alive on June 23, 1967 death is said to have occurred on the date stated above, at 7:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute myocardial infarction	20 min
Due To (b) Arteriosclerotic heart disease	10 yrs
Due To (c) Generalized arterio-sclerosis	12 yrs
OTHER SIGNIFICANT CONDITIONS Severe hypertrophic arthritis	15 yrs

Was autopsy performed? no
What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein Jr. M. D.
M. Traunstein, Jr., M.D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Date 6-24 1967
Winthrop, Mass.

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JUNE 27 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP MASS.

Received and filed JUN 26 1967 1967
John A Clair
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: WIDOWED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of HARRY J DWYER
(Husband's name in full)

12 AGE 80 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. HONE

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER CHARLES DAILY

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER CATHERINE HAYDE

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant ROBERT A. DWYER
(Address) 96 LORING RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip D. Vitaglione (R)
(Signature of Agent of Board of Health or other)
Dir of Public Health 6/26/67
(Official Designation) (Date of Issue of Permit)

-62-933404

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OUT - OF - TOWN

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 04778

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Declined By Medical Examiner

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

(City or Town making this return)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lottie E. Parsons (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 30 Bellevue Ave St. Winthrop Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from May 14, 1967, to May 14, 1967 we last saw her alive on May 14 1967 death is said to have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7-8 hrs

Due To (b) Hypertensive + Arterio Sclerotic Heart Disease — years

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify

(Signature) C. L. Clay, M. D.

(Print or Type Name)

(Address) Charles L. Clay, M.D. Ass't Dir., Mass. Gen'l Hosp. Date 5-14 67

6 Holy Cross Place of Burial or Cremation — Malden, Mass (City or Town)

DATE OF BURIAL May 17, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed MAY 18 1967

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of George E. Parsons (Husband's name in full)

12 AGE 88 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 022-01-2379A

16 BIRTHPLACE (City) (State or country) East Boston Mass

PARENTS

17 NAME OF FATHER John Kelliher

18 BIRTHPLACE OF FATHER (City) (State or country) New York

19 MAIDEN NAME OF MOTHER Catherine Tobin

20 BIRTHPLACE OF MOTHER (City) (State or country) New York

21 Informant George E. Parsons

(Address) 30 Bellevue Ave., Winthrop, Ma

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Kenneth W. Hurd (Signature of Agent of Board of Health or other)

E09324 (Official Designation) May 16, 1967 (Date of Issue of Permit)

Funeral Director: Please use only BLACK ink.

11 1967

DOM-8-66-943275

A TRUE COPY ATTEST:

William J. Kane,
City Registrar.

JUL 11

OFFICE OF THE
WINTHRO
JUL 11

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FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

UG 4 1967

OUT - OF - TOWN

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

(City or Town making this return)

Registered No. 05208

No. Massachusetts General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY (First Name) HARKINS (Middle Name) (Downey) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 11 Summit Avenue, St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 4 days. In place of residence 25 years ..... months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 31, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebral hemorrhage.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.

Michael A. Luongo, M.D. (Print or Type Name)

(Address) Boston Date 5/31 1967

7 Holy Cross Malden Mass (City or Town)

Place of Burial or Cremation.

DATE OF BURIAL June 2 1967

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed JUN 5 1967 19

William J. Kane

A TRUE COPY ATTEST (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Patrick W Harkins (Husband's name in full)

13 AGE 73 Years 5 Months 24 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: HOUSE WIFE (Kind of work done during most of working life)

15 Industry or Business: AT HOME

16 Social Security No. 022-20-4398

17 BIRTHPLACE (City) (State or country) NEWFOUNDLAND

PARENTS

18 NAME OF FATHER Joseph Downey

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER UNKNOWN

21 BIRTHPLACE OF MOTHER (City) (State or country) "

22 Informant (Address) Mary Palandro 21 Howard St Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Lorraine E 09926 (Signature of Agent of Board of Health or other)

(Official Designation) June 1 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-5-64-938000

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The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VETERANS COPY

1 PLACE OF DEATH: Middlesex (County); Somerville (City or Town)

Somerville (City or Town making this return)

Registered No. 326

No. Central Hospital Central St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Chester W. Orris (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW 11

(a) Permanent Residence. No. 19 Dartmouth St. Somerville, Mass. (City or town and State)

Length of stay: In place of death - years - months - days. In place of residence - years - months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Suicide Poisoning (Radiator Flush Oil)

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury June 9, 1967 19 7:30PM

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Sidney S. Listernick Ass. M. D. Med. Exam.

(Address) 37 Ferry St., Everett, Mass Date June 9 19 67

7 Place of Burial or Cremation. Winthrop Cem., Winthrop, Mass. (City or Town)

DATE OF BURIAL June 12, 19 67

8 NAME OF FUNERAL DIRECTOR Lawrence A. Willwerth

ADDRESS 179 Highland Ave., Somerville

Received and filed JUL 12 1967 19

John Allan
(Registrar of City or Town where deceased ~~resided~~) is buried

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR: White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

12 If married, widowed, or divorced HUSBAND of Marjorie A. McCarthy (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 40 Years 10 Months 23 Days — If under 24 hours Hours Minutes

14 Usual Occupation: Gas Station Attendant (Kind of work done during most of working life)

15 Industry or Business: Fuel Business

16 Social Security No.

17 BIRTHPLACE (City) (State or country) Alsey, Illinois

PARENTS

18 NAME OF FATHER Lee Orris

19 BIRTHPLACE OF FATHER (City) (State or country) Jacksonville, Ill.

20 MAIDEN NAME OF MOTHER Emma Miller

21 BIRTHPLACE OF MOTHER (City) (State or country) Jacksonville, Ill.

22 Informant (Address) Mrs. Marjorie A. Orris
35 Moore St.,
Winthrop, Mass.

A TRUE COPY ATTEST: William J. Donovan (Registrar of City or Town where death occurred)

DATE FILED June 12, 11:19 AM 19 67

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 2-4-49

DATE OF DISCHARGE 9-29-52

RANK, RATING PFC

ORGANIZATION AND OUTFIT U.S. Army

SERVICE NUMBER RA36928665

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R-305

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Plymouth
(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Plymouth (County); Plymouth (City or Town)

No. off Route 3, near WPLM Station St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard J. Porter (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 1079 ~~St~~ Shirley St St. Winthrop, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death none years ..... months ..... days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 18, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Compound fracture skull
Crushed chest and trachea
Multiple fractures

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury 6PM June 18 19 67
If accidental, was injury causally related to the death? yes ~~Plymouth, Mass~~
Where did Injury occur? Plymouth, Mass (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Airplane Route 3 (Specify type of place)
Manner of Injury Airplane struck guy wire (How did injury occur?)
Nature of Injury Guy wire caught airplane
While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) William C. Gould M. D.
(Address) Kingston, Mass Date June 18 19 67

7 Winthrop Winthrop
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL June 21, 1967 19

8 NAME OF FUNERAL DIRECTOR Maurice W Kirby
ADDRESS 210 Winthrop St, Winthrop

Received and filed JUL 13 1967 19
John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE
Male	white	YES ☐ NO ☐	single MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 DATE OF BIRTH

14 AGE 24 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Maintenance man (Kind of work done during most of working life)

16 Industry or Business: Eastern Air Line, Boston

17 Social Security No. -

18 BIRTHPLACE (City) (State or country) Winthrop Mass

PARENTS

19 NAME OF FATHER Ronald W Porter

20 BIRTHPLACE OF FATHER (City) (State or country) Somerville Mass

21 MAIDEN NAME OF MOTHER Evelyn M. Farrell

22 BIRTHPLACE OF MOTHER (City) (State or country) Jamaica Plain Mass

23 Informant (Address) Ronald W Porter 1079 Shirley St, Winthrop

A TRUE COPY.
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED June 19, 1967 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JAN 13 '67 AM

OFFICE OF THE [illegible]
WINTHROP, MASS.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

This does not mean
mode of dying,
h as heart failure,
henia, etc. It means
disease, or compli-
cions which caused
th.

Conditions, if any,
which gave rise to
bove cause (a),
tating the under-
ying cause last.

Conditions contrib-
ng to death but not
lated to the terminal
ease condition given
n (a).

The Commonwealth of Massachusetts

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KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

Winthrop (City or Town making this return)

No. WINTHROP COMMUNITY HOSPITAL St. LINCOLN ST. WINTHROP (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RUBY G TUCKER (Gillmore)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 393 PLEASANT ST. WINTHROP St. .....
(City or town and State)

Length of stay: In place of death.....years 2 months 1 days. In place of residence 65 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 4TH 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 3, 1967, to July 4, 1967. I last saw him alive on July 4, 1967, death is said to have occurred on the date stated above, at 10:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Generalized Carcinomatosis — 3 MOS.

Due To (b) Carcinoma of Pancreas — 5 MOS.

Due To (c) —

OTHER SIGNIFICANT CONDITIONS NONE.

Was autopsy performed? No.
What test confirmed diagnosis? Clinical + Lab.

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) M. Traunstein Jr. M.D. M.D.
M. TRAUNSTEIN JR. M.D.
(Print or Type Name)

(Address) 23 Bartlett Rd. Winthrop, Mass. Date July 4, 1967

6 Winthrop, Cemetery. Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 7, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 7 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Sidvin Frank Tucker
(Husband's name in full)

12 AGE 77 Years 2 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 025-26-3891-B

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Harry Creighton Gillmore

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Ida Floyd

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Massachusetts

21 Informant Sidvin F. Tucker

(Address) 393 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 7/7/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

1 for burial permit
oard of Health
its Agent.

ITRUCTIONS
FOR
IL CERTIFICATE

T OR TYPE
S OR CAUSES
D DEATH

d not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ise, or compli-
which caused

ions, if any,
ic gave rise to
cause (a),
the under-
cause last.

Conditions contrib-
death but not
do the terminal
condition given
)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 145

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 59 Beal St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Herbert Thomas Crosby
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 59 Beal ST. St. Winthrop
(Usual place of abode) (City or town and State)

Length of stay: In place of death 20 years — months — days. In place of residence 20 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 7:00 P.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
Due To (b) to natural causes.
Due To (c) Winthrop Board of Health
OTHER SIGNIFICANT CONDITIONS Charles Liberman MD

Was autopsy performed? No
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 7/7/ 19 67

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JULY 10, 19 67

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby
ADDRESS 210 Winthrop St.

Received and filed JUL 7 1967 19.....
John H Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male
9 COLOR white
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) married

11 If married, widowed, or divorced
HUSBAND of Eunice (Mokey) Crosby
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 62 Years — Months — Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation Navy Yard
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 025-34-9012

16 BIRTHPLACE (City) (State or country) BOSTON, MASS.

PARENTS

17 NAME OF FATHER Thomas Crosby
18 BIRTHPLACE OF FATHER (City) (State or country) not Known
19 MAIDEN NAME OF MOTHER Mary Kelley
20 BIRTHPLACE OF MOTHER (City) (State or country) not Known

21 Informant Mrs. Eunice Crosby
(Address) 59 Beal St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vetaglione (P)
(Signature of Agent of Board of Health or other)
Dir of Public Health 7/7/67
(Official Designation) (Date of Issue of Permit)

Reported to M.E. office - referred to Board of Health.

-162-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
ie, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
the terminal
ndition given

-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 146

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert F. Pratt
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 72 Temple Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1962, to July 9, 1967, I last saw h. alive on July 9, 1967, death is said to have occurred on the date stated above, at 7:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Pneumonia, Bilateral — 1 wk.

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Cerebral Arteriosclerosis — 5 yrs; Hypertension — 5 yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M.D.
Chas Liberman M.D., M. D.
(Print or Type Name)

(Address) 238 Shore Dr. Date 7/11 1967

6 Winthrop Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 174 Winthrop St., Winthrop

Received and filed JUL 13 1967 19
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of Katherine Lanciea
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 63 Years 8 Months 24 Days — If under 24 hours Hours Minutes

13 Usual Occupation: boiler inspector
(Kind of work done during most working life)

14 Industry or Business: Insurance

15 Social Security No. 020-05-4860

16 BIRTHPLACE (City) Salem
(State or country) Mass.

PARENTS

17 NAME OF FATHER James F. Pratt

18 BIRTHPLACE OF FATHER (City) Salem
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Crowley

20 BIRTHPLACE OF MOTHER (City) Salem
(State or country) Mass.

21 Informant James F. Pratt
(Address) 16 Oliver St., Brockton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 7/11/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP, MASS.
(City or Town making this return)

Registered No. 147

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN J. McLAUGHLIN
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 26 LOCUST ST., St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death.....years.....months...6...days. In place of residence 50...years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from July 8, 1967, to July 14, 1967
I last saw him alive on July 14, 1967, death is said to have occurred on the date stated above, at 10:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Arteriosclerotic Heart Disease — 6 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Pulmonary Emphysema — 5 yrs; Duodenal Ulcer — 1 wk

Was autopsy performed? NO
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 7/14/1967

6 Place of Burial or Cremation: Winthrop (City or Town): Winthrop
DATE OF BURIAL July 17, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed JUL 17 1967 John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Margaret Mackill
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 75 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Retired Custodian
(Kind of work done during most of working life)

14 Industry or Business: School

15 Social Security No.

16 BIRTHPLACE (City) So. Orange (State or country) New Jersey

PARENTS

17 NAME OF FATHER John McLaughlin

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen Tierney

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Margaret McLaughlin
(Address) 26 Locust St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MAK)
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 7/17/67 (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, phenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP, MASS.
(City or Town making this return)

Registered No. 148

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPHINE DOBSON
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 2 EDGAR TERRACE., St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death.....years.....months 5 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from april, 1966, to June 15, 1967
I last saw he alive on June 14, 1967, death is said to have occurred on the date stated above, at 5 10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 16 mos

Due To (b) Carcinoma of breast

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? pathology examination

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify No

(Signature) H. B. Greenfield, M. D.
(Print or Type Name)
(Address) 447 Shirley St Winthrop Date July 15 1967

6 Place of Burial or Cremation: Winthrop (City or Town): Winthrop
DATE OF BURIAL July 18, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed JUL 17 1967 John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Samuel Dobson
(Husband's name in full)

12 AGE 76 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: own Home

15 Social Security No.....

16 BIRTHPLACE (City) East Boston (State or country) Mass

PARENTS

17 NAME OF FATHER William Mulloy

18 BIRTHPLACE OF FATHER (City)..... (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Adelaide Crandall

20 BIRTHPLACE OF MOTHER (City) East Boston (State or country) Mass

21 Informant Zita Fulham
(Address) 33 Orlando Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaliano (Met)
(Signature of Agent of Board of Health or other)
Director of Public Health 7/17/67
(Official Designation) (Date of Issue of Permit)

1-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased bad retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

5M-6-60-928241

ORM R-304

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with Board of Health or its Agent.

Registered No. 149

1 PLACE OF DELIVERY: SUFFOLK (County) WINTHROP (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 NAME OF FETUS (if given): BABY GIRL DUVAL

3 DATE OF DELIVERY: 7/17/67 (Month) (Day) (Year)

4 SEX: Male ... Female X ... Undetermined ...

5 COLOR (if determined): W

6 THIS BIRTH (Check one): Single ✓ Twin ... Triplet

7 IF MULTIPLE BIRTH, BORN: 1st ... 2nd ... 3rd ...

In giving CAUSE OF FETAL DEATH do not enter more than one cause for each of (a), (b) and (c)

FATHER

8 FULL NAME: ERNEST H. DUVAL

9 RESIDENCE, NO. 169 BARTLT. RD STREET
CITY OR TOWN WINTHROP STATE MASS

10 COLOR OR RACE: WHITE

11 AGE AT TIME OF THIS DELIVERY: 38 (Years)

12 PLACE OF BIRTH: CHELSEA, (City or Town) MASSACHUSETTS (State or country)

13 OCCUPATION: MANAGER

MOTHER

14 MAIDEN NAME: GLORIA FARREN
PRESENT NAME: GLORIA DUVAL

15 RESIDENCE, NO. 169 BARTLT. RD. STREET
CITY OR TOWN WINTHROP STATE MASS

16 COLOR OR RACE: WHITE

17 AGE AT TIME OF THIS DELIVERY: 38 (Years)

18 PLACE OF BIRTH: WINCHESTER, (City or Town) MASSACHUSETTS (State or country)

19 INFORMANT: ERNEST H. DUVAL (HUSBAND)

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus): 6
(a) How many children are now living? 6
(b) How many children were born alive but are now dead? 0
(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY: 38 completed weeks

22 WEIGHT OF FETUS: 5 Lb. 10 Oz. (or ... Grams)

23 WHEN DID FETUS DIE? Before Labor ✓ During Labor or Delivery ... Unknown ...

24 AUTOPSY: Yes ... No ✓

...al or maternal ...lition causing ...l death (do ... use such ...s as stillbirth ... rematurity.) ...l and/or ma...al conditions, ...y, which gave ... to above ...e (a), stating ... underlying ...e last. →

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Premature Separation of Placenta
Due To (b)
Due To (c)

OTHER SIGNIFICANT CONDITIONS: none

→ ...litions of fetus ... mother which ... have contrib...td to fetal ...h, but, in so ...s is known, ... not related ... ause given ... a).

26 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 17, 1967 1967

27 NAME OF FUNERAL DIRECTOR: Maurice W. Kirby
ADDRESS: 210 Winthrop St. Winthrop

Received and filed JUL 17 1967 19...
John A Clark (Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 1:10 A m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
A. Paul DerHagopian M.D.
A. Paul DerHagopian
(PRINT OR TYPE SIGNATURE)
Address 39 CARY Av CHELSEA Date 7-17-67 19...

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglians (B)
(Signature of Agent of Board of Health or other)
Dir of Public Health 7/17/67
(Official Designation) (Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48, ACTS OF 1960.

*Section 2*A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

*Section 9*A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

FORM R-301

I be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean ie mode of dying, ich as heart failure, thenia, etc. It means ie disease, or campli- tions which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ing to death but not lated to the terminal ease condition given (a).

MEDICAL EXAMINER DECLINED JURISDICTION

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 150

1 PLACE OF DEATH: SUFFOLK (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Patterson, Mabelle C. (Ripley) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 10 Glen Road St. Saugus (City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 29, 1967, to JULY 18, 1967

I last saw her alive on JULY 18, 1967, death is said to have occurred on the date stated above, at 2:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR ACCT	6 HRS.
Due To (b) ARTERIO-SCLEROTIC HEART DIS	3 YRS
Due To (c) ☐ CONGESTIVE FAILURE BUNDLE BRANCH BLOCK	1 DAY
OTHER SIGNIFICANT CONDITIONS ARTHRITIS	3 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL + EKG

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron N. King, M. D.

MYRON N. KING MD (Print or Type Name)

(Address) 22 PLEASANT ST WINTHROP MASS Date 7/18 1967

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 21 1967

7 NAME OF FUNERAL DIRECTOR Bisbee & Son

ADDRESS 549 Lincoln Ave. Saugus

Received and filed JUL 21 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F.

9 COLOR W.

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William A. Patterson (Husband's name in full)

12 AGE 82 Years 4 Months 8 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Revere Mass.

PARENTS

17 NAME OF FATHER William A. Ripley

18 BIRTHPLACE OF FATHER (City) (State or country) C.N.B.L.

19 MAIDEN NAME OF MOTHER Adalaide C. Thomas

20 BIRTHPLACE OF MOTHER (City) (State or country) C.N.B.L.

21 Informant Robert G. Tillson

(Address) 24 Houston Ave. Wakefield

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 7/21/67 (Date of Issue of Permit)

1-8-66-943275

ıled - Sanqus 8-8-67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
: OR CAUSES
F DEATH

not enter
re than one
se for each
, (b) and (c)

does not meon
ode of dying,
heart foilure,
, etc. It meons
dose, or compli-
which caused

tions, if any,
gave rise to
cause (a),
the under-
cause last.

Conditions contrib-
death but not
to the terminal
condition given

2-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

WINTHROP (City or Town making this return)

Registered No. 151

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sylvia H. Korvek (Heino)
(If deceased was a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 86 Bowdoin St. St. Winthrop (City or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months...7...days. In place of residence 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 (Month) 20 (Day) 67 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7-20-, 1967, to 7-20-, 1967
I last saw he alive on 7-20-67, 19....., death is said to have occurred on the date stated above, at 12.30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CIRRHOSIS LIVER

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH 8 MO

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) A. N. Caplan, M. D.
A. N. CAPLAN MD
(Print or Type Name)
(Address) 166 BRINLETON ST. EBOSTON Date 7-20 1967

6 Winthrop Place of Burial or Cremation — Winthrop (City or Town)

DATE OF BURIAL 7-24- 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop, Mass.

Received and filed July 21, 1967

John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Stanley A. Korvek
(Husband's name in full)

12 AGE 51 Years.....Months.....Days — If under 24 hours ....Hours.....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business Own home

15 Social Security No. 012-14-2098

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Henevy Heino

18 BIRTHPLACE OF FATHER (City) - -
(State or country) Finland

19 MAIDEN NAME OF MOTHER Impi Satanna

20 BIRTHPLACE OF MOTHER (City) - -
(State or country) Finland

21 Informant Stanley A. Korvek
(Address) 86 Bowdoin St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board (or Health or other)

Dir of Public Health 7/21/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Maile

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 152

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Babson (Covell)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Permanent Residence. No. 6 Wave Way St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death.....years.....months 10 days. In place of residence.....years 6 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY (Month) 23 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from ....., 19....., to JULY 23, 1967

I last saw him alive on JULY 23, 1967, death is said to have occurred on the date stated above, at 9:35 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR HEMORRHAGE	3 DAYS
Due To (b) ARTERIO-SCLEROTIC HEART DIS.	5 YRS.
Due To (c) HYPERTENSIVE HEART DIS.	5 YRS
OTHER SIGNIFICANT CONDITIONS CARCINOMA OF LEFT BREAST ARTHRITIS	1 YR. 5 YRS

Was autopsy performed? No.
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP MASS Date 7/23 1967

6 TIFERETH ISRAEL EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JULY 24, 1967

7 NAME OF FUNERAL DIRECTOR ROBERT W. LeVINE
ADDRESS 1668 BEACON ST. BKLINE

Received and filed JUL 24 1967 19.....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of BENJAMIN BABSON (Husband's name in full)

12 AGE 85 Years..... Months..... Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME.

15 Social Security No.

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS
17 NAME OF FATHER Louis Covell
18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA
19 MAIDEN NAME OF MOTHER SARAH (UNKNOWN)
20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MANUEL SCOTCH
(Address) 6 WAVE WAY AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (Signature of Agent of Board of Health or other)
Dir of Public Health (Official Designation) 7/24/67 (Date of Issue of Permit)

1 1-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass. (City or Town making this return)

Registered No. 153

1 PLACE OF DEATH: Suffolk (County); Winthrop, Mass. (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Carl O. Prescott (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 118 Quincy Ave. St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death ..... years ..... months 28 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY (Month) 28 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/25/67, 19..., to JULY 28, 1967

I last saw him alive on JULY 28, 1967, death is said to have occurred on the date stated above, at 7:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR ACCT	2 DAYS
Due To (b) CARCINOMA of PROSTATE	10 YRS
Due To (c) metastases to bone	4 mo
OTHER SIGNIFICANT CONDITIONS ARTERIO SCLEROTIC HEART DIS. CONGESTIVE FAILURE	6 mt

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-ray

5 Was disease or injury in any way related to occupation of deceased No. If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. WINTHROP MASS. Date JULY 28 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 31, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 31 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of Freda R. Prescott (Reilly) (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 70 Years 9 Months 13 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired salesman (Kind of work done during most of working life)

14 Industry or Business: H.P. Hood Co.

15 Social Security No. 023-09-1810

16 BIRTHPLACE (City) Nashua (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Clifford H. Prescott

18 BIRTHPLACE OF FATHER (City) Westford (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Augusta E. Downing

20 BIRTHPLACE OF MOTHER (City) Dunstable (State or country) Massachusetts

21 Informant Bruce R. Prescott

(Address) 50 Summit Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 7/31/67
(Official Designation) (Date of Issue of Permit)

14-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, henia, etc. It means e disease, or compli- ions which caused ath.

Conditions, if any, which gave rise to above cause (a), toting the under- ying cause last.

Conditions contrib- ing to death but not ated to the terminal ease condition given i (a).

OUT-OF-TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Malden
(City or Town making this return)

Registered No. 154

1 PLACE OF DEATH: MIDDLESEX (County) MALDEN (City or Town)

No. MALDEN HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ERMENAGILDA SACCOCCIO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 90 MAIN St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY (Month) 31 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-5, 1967, to 7-31, 1967

I last saw her alive on 7-31, 1967, death is said to have occurred on the date stated above, at 5:40 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hepatic failure	3 mos
Due To (b)	Generalized Carcinomatosis	
Due To (c)	BREAST Adenoca (Left)	15 yrs
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no

What test confirmed diagnosis? Repeated operations

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify no

(Signature) Salvatore R Traina, M. D.
SALVATORE R. TRAINA
(Print or Type Name)

(Address) 155 HIGH ST MEDFORD Date 7-31 1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 3, 1967

7 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA
ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed AUG 2 1967 19

A TRUE COPY ATTEST: Nathan J. Schneiderman (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ANTHONY SACCOCCIO (Husband's name in full)

12 AGE 52 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation SCHOOL TEACHER (Kind of work done during most of working life)

14 Industry or Business: BOSTON PUBLIC SCHOOL

15 Social Security No. 011-01-0614

16 BIRTHPLACE (City) (State or country) BOSTON MASS

PARENTS

17 NAME OF FATHER MICHELE BRUNO

18 BIRTHPLACE OF FATHER (City) (State or country) ITALY

19 MAIDEN NAME OF MOTHER MARIA DIESO

20 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

21 Informant ANTHONY SACCOCCIO
(Address) 90 MAIN STREET, WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

John R. Ryan
(Signature of Agent of Board of Health or other)

Director of Public Health #47778 8/2/67
(Official Designation) (Date of Issue of Permit)

3 1967

1008-66-943275

TRUE COPY ATTEST:

Nathan J. Schneiderman

City Clerk

FORM R-303

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON 155
(City or Town making this return)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 155 96

1 PLACE OF DEATH: OUT - OF - TOWN
SUFFOLK (County)
BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME FRANCES (First Name) E. (TONRY) (Middle Name) McQUILLEN (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No 97 BEACH ROAD St. WINTHROP, MASSACHUSETTS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months days. In place of residence 80 years. months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
FRACTURE OF LEFT FEMUR;
HYPERTENSIVE ARTERIOSCLEROTIC
CARDIOVASCULAR DISEASE

5 Accident, suicide, or homicide (specify) ACCIDENT
Date and hour of injury MAY 10 19 67
IF ACCIDENTAL, was injury causally related to the death? YES
Where did Injury occur? WINTHROP, MASSACHUSETTS (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? IN HOME (Specify type of place)
Manner of Injury FALL (How did injury occur?)
Nature of Injury FRACTURE OF LEFT FEMUR
While at work? Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Leonard Atkins M. D.
LEONARD ATKINS, M.D.
(Print or Type Name)
(Address) 25 SHATTUCK ST. Date JUNE 10 1967

7 WINTHROP WINTHROP
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL JUNE 12 1967

8 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS 216 WINTHROP ST WINTHROP MASS

Received and filed JUN 13 1967
Catherine J. Shaw
(Registrar)

A TRUE COPY ATTEST.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: FEMALE
10 COLOR: WHITE
11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED ~~MARRIED~~

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of GEORGE J McQUILLEN
(Husband's name in full)

13 AGE 88 Years Months Days — If under 24 hours Hours Minutes

14 Usual Occupation: HOME MAKER
(Kind of work done during most of working life)

15 Industry or Business: HOME

16 Social Security No. 017-40-2994

17 BIRTHPLACE (City) EAST BOSTON
(State or Country) MASS.

PARENTS:
18 NAME OF FATHER JOHN TONRY
19 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)
20 MAIDEN NAME OF MOTHER FRANCES SKEEKY
21 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

22 Informant GEORGE J McQUILLEN
(Address) 16 MAGEE AVE, MALBORO, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Robert J. Samuels
(Signature of Agent of Board of Health or other)
E 10261 (Official Designation) 6/12/67 (Date of Issue of Permit)

NOTE: CHAPTER 117, ACTS OF 1967 ... HOSPITALS ... DEATH CERTIFICATES ... OFFICIAL ... DEATH ... FUNERAL DIRECTOR ... BURIAL OR TRANSIT PERMIT ... ISSUED.

N. B. WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93634B

G 18 1967

A TRUE COPY ATTEST:

William J. Bruce.

City Registrar

AUG 1 8

OFFICE OF :.

WINTHR

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

260
68

AUG 18 1967

DOM-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

156

BOSOTN (City or Town making this return)

Registered No. 05 [illegible]

1 PLACE OF DEATH: Suffolk (County)

Boston (City or Town)

No. U. S. Public Health Service Hospital XX (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James Charles Walsh (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 235 Bowdoin St. Winthrop, Mass. (City or town and State)

Length of stay. In place of death 0 years 0 months 4 days. In place of residence 43 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 19, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 15, 1967, to June 19, 1967. I last saw him alive on June 19, 1967 death is said to have occurred on the date stated above, at 4:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Severe diabetic acidosis with hypokalemia.	12 hrs
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS 1. Pulmonary congestion & edema, secondary to CHF.	12 hrs
2. Fatty infiltration of pancreas	3 wks.

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Alvin D. Blumberg M.D.

Alvin Blumberg, M. D. (Print or Type Name)

(Address) USPHSH, Boston, Mass. Date Jun 19, 1967

6 WINTHROP (Place of Burial or Cremation) WINTHROP (City or Town)

DATE OF BURIAL JUNE 22 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed JUN 22 1967

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced HUSBAND of CLARA M SHEEHAN (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 Years Months Days. If under 24 hours Hours Minutes

13 Usual Occupation FISH CUTTER. (Kind of work done during most of working life)

14 Industry or Business FISH PIER.

15 Social Security No. 025-03-4797

16 BIRTHPLACE (City) (State or country) SOUTH BOSTON MASS

PARENTS

17 NAME OF FATHER THOMAS WALSH

18 BIRTHPLACE OF FATHER (City) (State or country) BOSTON

19 MAIDEN NAME OF MOTHER MARY POWERS

20 BIRTHPLACE OF MOTHER (City) (State or country) N. F.

21 Informant CLARA M. WALSH

(Address) 235 BOWDOIN ST, WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. P. Graca E 10607 (Signature of Agent of Board of Health or other)

(Official Designation) June 20, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Lee

City Registrar

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

157

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Norfolk (County); Wrentham (City or Town)

Wrentham (City or Town making this return)

No. Wrentham State School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Edward Kennedy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 10 Marshall St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 7 years 10 months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 19, 64, to July 1, 67, I last saw him alive on July 1, 67, death is said to have occurred on the date stated above, 2.20 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Meningoencephalomyelitis	6 days
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Phenylpyruvic Oligophrenia Mental deficiency-severe life	15 yrs

Was autopsy performed? no

What test confirmed diagnosis? Physical signs

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signature) Edward K. Pearson, M. D.

(Address) Wrentham, Mass. Date 7-1 1967

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL July 5 67

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby Funeral Home

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed AUG 24 1967 19..

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 15 Years 6 Months 1 Days; If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Resident of Wrentham State School
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) (State or country): Washington D.C.

PARENTS

17 NAME OF FATHER: Richard M. Kennedy

18 BIRTHPLACE OF FATHER (City) (State or country): East Boston Mass.

19 MAIDEN NAME OF MOTHER: Marie C. Ward

20 BIRTHPLACE OF MOTHER (City) (State or country): Newark New Jersey

21 Informant: Records of Wrentham State School

(Address) Wrentham, Mass.

A TRUE COPY

ATTEST: George L. Perry
(Registrar of City or Town where death occurred)

DATE FILED July 7, 1967 19..

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

AUG 24 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

158

(City or Town making this return)

Registered No. 424

1 PLACE OF DEATH: NORFOLK (County); BROOKLINE (City or Town)

No. Boston Hospital for Women-Parkway Division St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Felicia Frazier (Kwiatowski)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 59 Lewis Avenue x Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 16 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: July (Month) 5, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 14, 1967 to July 5, 1967
I last saw her alive on July 5, 1967, death is said to have occurred on the date stated above, at 7:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Disseminated Carcinoma of Cervix	3½ yrs.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) David S. Bard, M. D.
245 Pond Ave.
(Address) Brookline, Mass. Date July 5, 1967

6 Winthrop Cemetery-Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 8 1967

7 NAME OF FUNERAL DIRECTOR: Ernest P. Caggiano
ADDRESS: 147 Winthrop St. Winthrop, Mass.

Received and filed SEP 1 1967
John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of William H. Frazier (Husband's name in full)

12 AGE 51 Years 1 Months 5 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. none

16 BIRTHPLACE (City) Chelsea (State or country) Mass.

PARENTS

17 NAME OF FATHER: Paul Kwiatowski

18 BIRTHPLACE OF FATHER (City) (State or country) Poland

19 MAIDEN NAME OF MOTHER: Helen (cannot be learned)

20 BIRTHPLACE OF MOTHER (City) (State or country) Poland

21 Informant: William H. Frazier
(Address) 59 Lewis Ave. Winthrop, Mass.

A TRUE COPY
ATTEST: Thomas F. Larkin
(Registrar of City or Town where death occurred)

DATE FILED July 6, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

SEP 1 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

159

Danvers
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Essex (County); Danvers (City or Town)

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William H. McGillicuddy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permane. ·sidence. No. 39 Pico Avenue St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ....years 1 months 5 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 24, 19 67 to July 29, 19 67

I last saw him alive on July 29, 19 67, death is said to have occurred on the date stated above, at 6:20 p.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wek

Due To (b) Nephrosclerosis — years

Due To (c) Generalized arteriosclerosis — yrs.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus — mos.

Was autopsy performed? No
What test confirmed diagnosis? Clinical&Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 7/29/67 19

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 19 67

7 NAME OF FUNERAL DIRECTOR O'Maley Funeral Home

ADDRESS Winthrop, Mass.

Received and filed AUG 15 1967 19

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of Mary Harron
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 82 Years 5 Months 29 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Meat Salesman
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 023-01-7181

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Daniel E. McGillicuddy

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine Connolly

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY — ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED August 7 19 67

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

VM

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

160

(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 1114

1 PLACE OF DEATH: Middlesex (County) — Cambridge (City or Town)

No. Holy Ghost Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Norma Patrick (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 455 Shirley St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..years 2 months ..days. In place of residence 40 years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 29, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 29, 1967, to July 29, 1967. I last saw her alive on July 28, 1967, death is said to have occurred on the date stated above, at 7:15 AM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To (b) Reticulum Cell Sarcoma

Due To (c) Right Parietal Lobe of Brain

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ..

If so, specify

(Signature) William H. Garvin, Jr., M.D., M. D.
" " " " "

(Address) Holy Ghost Hosp. Date 7/29/ 1967

6 Puritan Lawn Peabody
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed SEP 6 1967 19..

John A Clare
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Single

11 If married, widowed, or divorced
HUSBAND of ..
(Give maiden name of wife in full)
(or) WIFE of ..
(Husband's name in full)

12 AGE 68 Years 9 Months 21 Days — If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Piano Teacher (Kind of work done during most of working life)

14 Industry or Business: Self

15 Social Security No. 030-01-3379

16 BIRTHPLACE (City) Keene (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Samuel Patrick

18 BIRTHPLACE OF FATHER (City) c.n.b.l., (State or country) Vermont

19 MAIDEN NAME OF MOTHER Susan Applin

20 BIRTHPLACE OF MOTHER (City) c.n.b.l., (State or country) Vermont

21 Informant Lewis Patrick

(Address) 8 Garrison St., Boston, Mass.

A TRUE COPY Thomas Andre Damara

ATTEST: ..
(Registrar of City or Town where death occurred)

DATE FILED July 31, 1967 19..

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS

MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

OUT - OF - TOWN

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea 161
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 333

1 PLACE OF DEATH: Suffolk (County) Chelsea (City or Town)

No. Soldiers' Home Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nicholas F. TALLINI (Also known as Nicholas F. Tallini, Frank N. Tallini) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) W.W.I

(a) Permanent Residence No. 40 Ocean St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death Hospital years 1 months 15 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6/15, 1967, to 7/30, 1967. I last saw him alive on 7/30, 1967. Death is said to have occurred on the date stated above, at 9:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral embolism (Cerebral embolism)

Due To (b) Cerebrovascular disease (Cerebrovascular disease)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Bronchogenic cyst (Bronchogenic cyst)

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) R. Zelaya, M.D., M. D.

R. ZELAYA, M.D (Print or Type Name)

(Address) Soldiers' Home Hosp. Date 7/30 1967

6 Place of Burial or Cremation: Winthrop Cem. (City or Town) Winthrop, Mass.

DATE OF BURIAL August 2 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano & Son

ADDRESS 147 Winthrop St., Winthrop, Mass.

Received and filed Aug. 3 1967

M. P. Dale (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Divorced

11 If married, widowed, or divorced HUSBAND of Mary Wedserspoon (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 7 Months 25 Days. If under 24 hours Hours Minutes

13 Usual Occupation Salesman (Kind of work done during most of working life)

14 Industry or Business: Not known

15 Social Security No. 339-05-0655

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Gennaro Gennaro Tallini

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Cesera Lebaffe

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Hospital Record

(Address) 91 Crest Ave. Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. Blake, M.D. (Signature of Agent of Board of Health or other)

Agent July 31, 1967 (Official Title) (Date of Permit)

AUG 21 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 9/6/18

DATE OF DISCHARGE 2/4/19

RANK, RATING Pvt.

ORGANIZATION AND OUTFIT U.S.A. - Adj. Gen't Personnel Sect. Army Civ. 77

SERVICE NUMBER 4902870

AUG 21 '67 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

CITY OF CHELSEA
RECEIVED
AUG 1 - 1967
BOARD OF HEALTH

A TRUE COPY ATTEST:

John P. Dahl

City Clerk

R-301A

UCTIONS
FOR
CERTIFICATE

giving
OF DEATH

ot enter
than one
for each
b) and (c)

es not mean
of dying,
heart failure,
tc. It means
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-69-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 162

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. 63 Summit Ave., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Walter W. Corcoran (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW#2

(a) Residence. No. 63 Summit Ave. (Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death 20 years ... months ... days. In place of residence 20 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: August (Month) 1 (Day), 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1964, to Aug. 1, 1967. I last saw him alive on Aug. 1, 1967, death is said to have occurred on the date stated above, at 9:47 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion	1 day
Due To (b) Hypertensive Arterio sclerotic Heart DISEASE	1 yr.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: None	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)
(Address) WINTHROP, MASS Date 8/1/1967

6 Winthrop — Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 4, 1967

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley
ADDRESS: Winthrop, Mass.

Received and filed AUG 3 1967 19
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Eleanor Barter (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 44 Years ... Months ... Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Salesman (Kind of work done during most of working life)

14 Industry or Business: Shoe Business

15 Social Security No. 031-22-0979

16 BIRTHPLACE (City) (State or country): Dover, New Hampshire

PARENTS

17 NAME OF FATHER: Walter Corcoran

18 BIRTHPLACE OF FATHER (City) (State or country): C.B.L.

19 MAIDEN NAME OF MOTHER: Johanna Kenney

20 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

21 Informant (Address): Eleanor Corcoran, 63 Summit Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (B)
(Signature of Agent of Board of Health or other)

Tie of Public Health 8/3/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 10-2-42

DATE OF DISCHARGE 9-24-45

RANK, RATING ..... Coxswain

ORGANIZATION AND OUTFIT ..... U.S. Navy

SERVICE NUMBER 573 01 94

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following les of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, phenia, etc. It means disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 163

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HERBERT PERMATTEO
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 69 LINCOLN ST., St. WINTHROP, MASS 02152
(City or town and State)

Length of stay: In place of death ..years..months 2 days. In place of residence 30 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 2 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from 7-31, 1967, to 8-2, 1967

I last saw h. alive on Aug 2, 1967 death is said to have occurred on the date stated above, at 6:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral vascular accident

Due To (b) arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS myocardial infarction (acute) Buerger's disease

INTERVAL BETWEEN ONSET AND DEATH: days

Was autopsy performed? No

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify No

(Signature) N. B. Greenfield, M. D.

N. B. Greenfield
(Print or Type Name)

(Address) Winthrop Date 8-2 1967

6 Place of Burial or Cremation: WINTHROP (City or Town) WINTHROP

DATE OF BURIAL Aug 5 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed AUG 3 1967 19..

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced HUSBAND of CECILE PERRIER
(Give maiden name of wife in full)

(or) WIFE of ..
(Husband's name in full)

12 AGE 61 Years 13 Months ..Days. If under 24 hours ..Hours..Minutes

13 Usual Occupation RETIRED INSURANCE MAN
(Kind of work done during most of working life)

14 Industry or Business: MET LIFE INS.

15 Social Security No. 030-09-2998

16 BIRTHPLACE (City) REVERE (State or country) MASS

PARENTS

17 NAME OF FATHER DOMENIC PERMATTEO

18 BIRTHPLACE OF FATHER (City) .. (State or country) ITALY

19 MAIDEN NAME OF MOTHER MARY STERBI

20 BIRTHPLACE OF MOTHER (City) .. (State or country) Italy

21 Informant CECILE PERMATTEO

(Address) 69 LINCOLN ST WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (mcd)
(Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 8/3/67 (Date of Issue of Permit)

10 8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 164

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 42 Loring Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lottie S. Keating (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 42 Loring Road St. (City or town and State)

Length of stay: In place of death 35 years months days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1967, to Aug. 5, 1967

I last saw her alive on Aug 1, 1967 death is said to have occurred on the date stated above, at 6 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cardio-renal failure	2 months
Due To (b) Gen. arteriosclerosis	2 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No.

What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signature) Charles Meloni, M. D.

CHARLES MELONI (Print or Type Name)

(Address) 45 Bayswater St. E Boston Date Aug 5 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 7 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed August 7, 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of James S. Keating (Husband's name in full)

12 AGE 75 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Robert L. Smith

18 BIRTHPLACE OF FATHER (City) (State or country) Germany

19 MAIDEN NAME OF MOTHER Julia Carney

20 BIRTHPLACE OF MOTHER (City) (State or country) New Brunswick

21 Informant Beverly Keating

(Address) 42 Lorind Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Mck) (Signature of Agent of Board of Health or other)

Director of Public Health 8/7/67 (Official Designation) (Date of Issue of Permit)

10-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asphenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass.
(City or Town making this return)

Registered No. 165

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edith Sampson (Boudreau)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 146 Princeton St. St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 5, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 61, to August 5, 1967
I last saw him alive on Aug. 5, 1967, death is said to have occurred on the date stated above, at 10:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic and — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.

Due To (b) Rheumatic Heart Disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cirrhosis of liver — 10 yrs. Diabetes Mellitus — 5 yrs.

Was autopsy performed? ....
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ....

(Signature) Charles Liberman M. D.
Charles Liberman M.D.
(Print or Type Name)
(Address) 238 Shore Drive Winthrop, Mass. Date 8/5/ 1967

6 Place of Burial or Cremation Holy Cross (City or Town) Malden
DATE OF BURIAL Aug. 9 1967

7 NAME OF FUNERAL DIRECTOR Frederick T. Magrath
ADDRESS East Boston

Received and filed August 8, 1967
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Leo W. Sampson
(Husband's name in full)

12 AGE 67 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housework
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) ....
(State or country) Canada

PARENTS

17 NAME OF FATHER Simon Boudreau

18 BIRTHPLACE OF FATHER (City) ....
(State or country) Canada

19 MAIDEN NAME OF MOTHER Louise Fougere

20 BIRTHPLACE OF MOTHER (City) ....
(State or country) Canada

21 Informant Louise B. Murphy
(Address) 274 Havre St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/8/67
(Official Designation) (Date of Issue of Permit)

10(8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
vith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean
mode of dying,
h as heart failure,
henia, etc. It means
disease, or compli-
ions which caused
ath.

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

Conditions contrib-
ing to death but not
lated to the terminal
ease condition given
in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 166

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARIA (DiGIAMBITTORIO) DiGianwittorio) CHIULLI
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 20 HERMON ST. St. WINTHROP MASS.
(City or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 15 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 8, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1964, to Aug. 8, 1967
I last saw he alive on Aug. 8, 1967, death is said to have occurred on the date stated above, at ....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Coronary Occlusion, acute — 1 WK.
Due To (b) Hypertensive Arteriosclerotic — 1 yr.
Due To (c) Heart Disease
OTHER SIGNIFICANT CONDITIONS Hypothyroidism. — 1 yr

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 8/8/1967

6 Place of Burial or Cremation: Winthrop Cemetery (City or Town) Winthrop
DATE OF BURIAL August 11 1967

7 NAME OF FUNERAL DIRECTOR Vincent R. Rapino
ADDRESS 9 Chelsea St., S. Boston, Mass.

Received and filed August 10, 1967
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Sabatino Chiulli
(Husband's name in full)

12 AGE 70 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 029-05-6095B

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Michael DiGianwittorio

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Adeline Aniello

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Sabatino Chiulli (husband)
(Address) 20 Hermon St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (nce)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/10/67
(Official Designation) (Date of Issue of Permit)

1008-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301A

NSTRUCTIONS FOR ICAL CERTIFICATE

In giving SE OF DEATH

lo not enter ore than one use for each a), (b) and (c)

is does not mean node of dying, as heart failure, a, etc. It means sease, or compli- which caused

itions, if any, gave rise to cause (a), g the under- cause last.

Conditions contrib- to death but not to the terminal condition given a

- Chapter 137, 1954, requires ans to print or he cause or of death on certificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP

To be filed for burial permit with Board of Health or its Agent.

Registered No. 167

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank Reni
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 36 East Newton St. Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ___ years 1 months ___ days. In place of residence 50 years ___ months ___ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 29, 1967 to Aug. 8, 1967
I last saw him alive on Aug. 6, 1967, death is said to have occurred on the date stated above, at 10:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Generalized Carcinomatosis	2 Mos.
Due To (b) Carcinoma of Prostate	1½ yrs.
Due To (c) None	
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No
What test confirmed diagnosis? Clinical + Laboratory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) M. Frauenstein, Jr., M. D.
(Address) 73 Bartlett Rd Winthrop Mass. Date Aug 8, 1967

6 Place of Burial or Cremation St. Michaels Roslindale (City or Town)
DATE OF BURIAL Aug 12 1967

7 NAME OF FUNERAL DIRECTOR Dello Russo Fun. Ser.
ADDRESS 306 Main St. Medford

Received and filed AUG 10 1967 19
John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR Caucasian
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Divorced

10a If married, widowed, or divorced HUSBAND of Elizabeth (Paul)
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years ___ Months ___ Days If under 24 hours ___ Hours ___ Minutes

13 Usual Occupation: Cab Driver
(Kind of work done during most of working life)

14 Industry or Business: Ralph Peters, Boston

15 Social Security No. 025-03-6781

16 BIRTHPLACE (City) (State or country) Boston

PARENTS
17 NAME OF FATHER Emilio
18 BIRTHPLACE OF FATHER (City) (State or country) Italy
19 MAIDEN NAME OF MOTHER Irma Reviati
20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mrs Priscilla D'Onofrio
(Address) 916 - Hyde Park Ave, Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/10/67
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration nf his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb tn another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... .— General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

M R-303

ed for burial permit
Board of Health
r its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 168

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. Waters off Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOSEPH J. WALSH
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. (Usual place of abode) No. 201 Pleasant Street, St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 19 years ... months ... days. In place of residence 19 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Asphyxia due to drowning. Senility
Carcinoma of prostate.

5 Accident, suicide, or homicide (specify) Presumably accidental
Date and hour of injury August 9, 19 67
IF ACCIDENTAL, was injury causally related to the death?
Where did Injury occur? Winthrop, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Waters off Winthrop. (Specify type of place)
Manner of Injury Accidental fall into water. (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 8/9 67 19

7 Place of Burial or Cremation. Holy Cross, Malden, Mass. (City or Town)
DATE OF BURIAL August 12, 1967 19

8 NAME OF FUNERAL DIRECTOR William J. Killion
ADDRESS 1 Sprague St. Revere, Mass.
Received and filed August 11, 19 67
A TRUE COPY ATTEST: John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male
10 COLOR white
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) widowed

12 If married, widowed, or divorced HUSBAND of Katherine McNeil
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 AGE 90 Years 0 Months 8 Days
If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Motor car (electric) oper.
(Kind of work done during most of working life)

15 Industry or Business: Street railway transit

16 Social Security No. 024-10-4773-A

17 BIRTHPLACE (City) (State or country) Charlottetown, P.E.I.

PARENTS
18 NAME OF FATHER John Walsh
19 BIRTHPLACE OF FATHER (City) (State or country) Ireland
20 MAIDEN NAME OF MOTHER Margaret Carroll
21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant John M.J. Walsh
(Address) 201 Pleasant St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/11/67
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

COVERING FOR DR. H. GREENFIELD ON VACATION
MEDICAL EXAMINER NOT FIED—DECLINED JURISDICTION

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 169

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Maude Evelyn Hallett (Smith) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 58 Otis Street St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years 18 months ..... days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JULY 31, 1967, to AUG 14, 1967

I last saw her alive on AUG 14, 1967 death is said to have occurred on the date stated above, at 5:20 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) GENERAL CARCINOMATOSIS	1 mo.
Due To (b) CARCINOMA OF BREAST	2 YRS
Due To (c) ARTERIO-SCLEROTIC HEART DI PYELONEPHRITIS	2 YRS
OTHER SIGNIFICANT CONDITIONS SENILE DEMENTIA DIABETES MELLITUS	1 MO

Was autopsy performed? NO.

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron N King, M. D.

MYRON N. KING MD (Print or Type Name)

(Address) 202 PLEASANT ST WINTHROP MASS Date 8/14 1967

6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed August 16, 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Frank Parker Hallett (Husband's name in full)

12 AGE 80 Years 1 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 002-05-6726

16 BIRTHPLACE (City) Somerville (State or country) Massachusetts

PARENTS

17 NAME OF FATHER Albert Smith

18 BIRTHPLACE OF FATHER (City) Somerville (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Nettie Carlo

20 BIRTHPLACE OF MOTHER (City) Somerville (State or country) Massachusetts

21 Informant Mrs. William T. Kinney

(Address) 23 A. Taft Avenue

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip A. Vitagliano (B) (Signature of Agent of Board of Health or other)

Dir. of Public Health 8/16/67 (Official Designation) (Date of Issue of Permit)

100M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 170

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ROSE (LURENSKY,) BOIARSKY
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 110 LORING ROAD St. WINTHROP, MASSACHUSETTS
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 19 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST (Month) 15, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 1957, to Aug. 15, 1967
I last saw her alive on Aug. 15, 1967, death is said to have occurred on the date stated above, at 8:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebrovascular — 3wks
Due To (b) Occlusion with Left
Due To (c) Hemiplegia
OTHER SIGNIFICANT CONDITIONS Hypertensive Arteriosclerotic Heart Disease — 5yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 8/15/1967

6 KENNESSETH ISRAEL - WOBURN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 16 1967

7 NAME OF FUNERAL DIRECTOR ROBERT W. LeVine
ADDRESS 1669 BEACON ST. BROOKLINE

Received and filed AUG 15 1967 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of BENJAMIN BOIARSKY
(Husband's name in full)

12 AGE 78 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: At HOME

15 Social Security No. unknown

16 BIRTHPLACE (City) ..... (State or country) Russia

PARENTS

17 NAME OF FATHER ELIZ LURENSKY

18 BIRTHPLACE OF FATHER (City) ..... (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER HANNA (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) RUSSIA

21 Informant DR. SAMUEL H. BOYER
(Address) 60 BROOKLINE ST, CHESTNUT HILL

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation)
8/15/67
(Date of Issue of Permit)

100M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 171

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home 142 Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph T Ratajczyk (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 68 Walnut St. Chelsea (City or town and State)

Length of stay: In place of death ....years 1 months 14 days. In place of residence 53 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 17, 1967, to August 15, 1967

I last saw h....alive on August 13, 1967, death is said to have occurred on the date stated above, at 6:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia Terminal — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

Due To (b) Carcinoma of Lung — Months

Due To (c) ....

OTHER SIGNIFICANT CONDITIONS: Metatastic Carcinoma of Brain — Months

Was autopsy performed? ....

What test confirmed diagnosis? ....

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify ....

(Signature) Joseph Gregorie, M. D.

Joseph Gregorie (Print or Type Name)

(Address) 194 Washington Ave Date 8/15 1967

6 Place of Burial or Cremation: Holy Cross Malden (City or Town)

DATE OF BURIAL 17 August 1967

7 NAME OF FUNERAL DIRECTOR Walter S Walata Jr

ADDRESS 125 Washington Ave Chelsea

Received and filed AUG 15 1967 19....

John A Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Mary Saschuk (Give maiden name of wife in full)

(or) WIFE of .... (Husband's name in full)

12 AGE 53 Years ....Months ....Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: General Laborer (Kind of work done during most of working life)

14 Industry or Business: Mystic Docks

15 Social Security No. 022 07 8640

16 BIRTHPLACE (City) Chelsea (State or country) Mass

PARENTS

17 NAME OF FATHER: Thomas Ratajczyk

18 BIRTHPLACE OF FATHER (City) Poland (State or country)

19 MAIDEN NAME OF MOTHER: Josephine Brill

20 BIRTHPLACE OF MOTHER (City) Poland (State or country)

21 Informant Mrs Helen Cichonska

(Address) 208 Clark Ave Chelsea Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 8/15/67 (Date of Issue of Permit)

100M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

CODING

STATE OF NEW HAMPSHIRE

TOWN OR CITY CLERK'S NO. 747

STATE FILE NO.

DATE OF DEATH

PLACE OF DEATH

INSTITUTION

RESIDENCE

SEX

SC

AGE

OCCUPATION

BIRTHPLACE

CITIZENSHIP

VETERAN

CAUSE OF DEATH

DIAGNOSIS

1. NAME OF DECEASED (TYPE OR PRINT) A. (FIRST) William B. (MIDDLE) Creswald C. (LAST) Hughes

2. DATE OF DEATH (MONTH) (DAY) (YEAR) 8/17/67

3. PLACE OF DEATH
A. COUNTY Hillsborough
B. CITY OR TOWN Manchester
C. LENGTH OF STAY (IN THIS PLACE) 41 Days
D. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) V. A. Hospital

4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION.)
A. STATE Mass. B. COUNTY Middlesex
C. CITY OR TOWN (GIVE ACTUAL TOWN OF RESIDENCE. NOT MAILING ADDRESS). Lowell
D. STREET ADDRESS (IF RURAL, GIVE LOCATION) 236 Hale St.
E. IS RESIDENCE ON FARM? YES ☐ NO ☒

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐
8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE) Norma Ford

9. DATE OF BIRTH 4/29/01
10. AGE (IN YEARS LAST BIRTHDAY) 66 IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Truck driver
11B. KIND OF BUSINESS OR INDUSTRY Transportation

12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Liverpool, England
13. CITIZEN OF WHAT COUNTRY? USA
14. FATHER'S NAME William Hughes

15. MOTHER'S MAIDEN NAME Thomasina Larmour
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES OF SERVICE) WWI
17. SOC. SEC. NO. 011-01-2781

18A. INFORMANT V. A. Hospital Records
18B. ADDRESS 718 Smyth Rd., Manchester, N.H.

MEDICAL CERTIFICATION

19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (A) Anemia, severe (DiGuglielmo's Syndrome) — INTERVAL BETWEEN ONSET AND DEATH: 2 Yrs.
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.
DUE TO (B)
DUE TO (C)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A)
Congestive heart failure.
20. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

21A. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 19.)
21C. TIME OF INJURY MONTH DAY YEAR HOUR M.
21D. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21E. PLACE OF INJURY (E.G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)
21F. CITY, TOWN OR LOCATION COUNTY STATE

22A. VA attended the deceased from 7/7/67, to 8/17/67 and last saw ~~her~~ him alive on 8/17/67.
Death occured at 11:20A m on the date stated above; and to the best of my knowledge, from the causes stated.

23A. SIGNATURE Roger H. Wright, M. D. (DEGREE OR TITLE)
23B. ADDRESS VAH, Manchester, N. H.
23C. DATE SIGNED 8/18/67

24A. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐
24B. DATE 8/21/67
24C. NAME OF CEMETERY OR CREMATORY Winthrop Cem.
24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.
24E. PLACE OF BURIAL IF ENTOMBED (NAME OF CEMETERY) LOCATION (CITY, TOWN, COUNTY) (STATE) DATE

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard Reynolds, Winthrop, Mass.
COUNTERSIGNED-AGENT (CITY BD. OF HEALTH) James J. Powers, M.D.
DATE 8/21/67

DATE REC'D BY TOWN OR CITY CLERK 8/21/67
CLERK'S OWN SIGNATURE L. P. Keane
CLERK OF Manchester, N. H.

A true copy, Attest: [signature] Clerk of Manchester Dated 8/21/ 19 67

VS 1E 7-66—10M 50228-x

AUG 22 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers (City or Town making this return)

Registered No. 173

1 PLACE OF DEATH: Essex (County); Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Louis Kerimel
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 150 Locust St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ....years....months 29 days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: August 17, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 18, 1967, to August 17, 1967, I last saw h. alive on August 17, 1967, death is said to have occurred on the date stated above, at 5:00p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Addison's disease	yrs.
Due To (b) L. B. left adrenal gland	yrs.
Due To (c) Ulceration Esophagus	?
OTHER SIGNIFICANT CONDITIONS: Chronic pancreatitis	mos.
Infarct of spleen	mos.

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 8/19/67 19

6 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 21 19 67

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed AUG 28 1967 19....

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
male	white	married

11 If married, widowed, or divorced
HUSBAND of Lucienne Heurgue
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 74 Years 10 Months 14 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Jewler (retired)
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 010-09-9648

16 BIRTHPLACE (City) Binic
(State or country) France

PARENTS

17 NAME OF FATHER Louis Kerimel

18 BIRTHPLACE OF FATHER (City) .....
(State or country) France

19 MAIDEN NAME OF MOTHER Marie Feuillet

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) France

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED August 24 19 67

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

AUG 28 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP MASS.

M

FORM R-301

d for burial permit
ard of Health
Agent.

STRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

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use for each
), (b) and (c)

does not meon
sode of dying,
s heart failure,
a, etc. It meons
eeose, or compli-
which coused

litions, if ony,
h gave rise to
e couse (o),
ng the under-
couse lost.

nditions contrib-
o deoth but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 174

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME AGNES M DRISCOLL
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 99 Winthrop St., St.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ....years 2 months ....days. In place of residence 50 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 10, 1946, to August 19, 1967. I last saw he alive on August 19, 1967 death is said to have occurred on the date stated above, at 7:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic + Hypertensive Heart Disease	10 YRS
Due To (b) Generalized Arteriosclerosis	15 YRS
Due To (c) —	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	15 YRS
Pernicious Anemia	25 YRS

Was autopsy performed? No
What test confirmed diagnosis? Clinical + Laboratory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) M. Traunstein Jr. M. D.
M. TRAUNSTEIN JR. M.D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Winthrop, Mass. Date Aug 19, 1967

6 Place of Burial or Cremation Winthrop (City or Town) Winthrop

DATE OF BURIAL August 23, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed AUG 22 1967 19....
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Maurice F. Driscoll
(Husband's name in full)

12 AGE 81 Years ....Months ....Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

17 NAME OF FATHER Nicholas Fitzgerald

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Margaret Hannigan

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Dorothy Bowditch
(Address) 99 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 8/22/67
(Official Designation) (Date of Issue of Permit)

2-62-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

o be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 175

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lorenzo R Cobos
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 19 Elm St St. Lynn Mass (City or town and State)

Length of stay: In place of death ....years ....months 4 days. In place of residence 50 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 22 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1967, to Aug 22, 1967. I last saw him alive on Aug 20, 1967, death is said to have occurred on the date stated above, at 10:30 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yrs
Due To (b) Arteriosclerosis - Gen	yrs
Due To (c)	yrs
OTHER SIGNIFICANT CONDITIONS Emphysema	yrs
Senility	yrs

Was autopsy performed? ....
What test confirmed diagnosis? ....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ....

(Signature) Joseph Gregorie, M. D.
Joseph Gregorie (Print or Type Name)
(Address) 94 Washington Date 8-22 1967

6 Harmony Grove Salem Mass
XXXXXXXXXX Burial or Cremation (City or Town)

DATE OF BURIAL August 25 1967

7 NAME OF FUNERAL DIRECTOR Goodrich Funeral Home

ADDRESS 128 Washington St Lynn Mass

Received and filed AUG 23 1967
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Bessie May Hassett
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 82 Years 9 Months 8 Days. If under 24 hours: Hours Minutes

13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business: Elec Eng. Gen Elec R.W.

15 Social Security No. 024-16-5276-A

16 BIRTHPLACE (City) Bayamon (State or country) Puerto Rico

PARENTS

17 NAME OF FATHER Gregorio Cobos

18 BIRTHPLACE OF FATHER (City) Salamanaca (State or country) Spain

19 MAIDEN NAME OF MOTHER Marie Louise Cavanne

20 BIRTHPLACE OF MOTHER (City) Versailles (State or country) France

21 Informant Marie C Reynolds
(Address) 4307 42nd St Sunnyside Long Island N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCX)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/23/67
(Official Designation) (Date of Issue of Permit)

100M-5-64-938000

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

176

1 PLACE OF DEATH: Middlesex (County) — Cambridge (City or Town)

Cambridge (City or Town making this return)

Registered No. 1247

No. Holy Ghost Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gladys Driscoll (Turner) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence No. 115 Winthrop St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 2 months 19 days. In place of residence 19 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Carcinoma of Sigmoid with Hydronephrosis, right and Confluent Bronchopneumonia complicating Fracture of Left Hip. Injury received in Fall in Home. Accident.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury Sept. 5, 1966 at 8:30A.M.

IF ACCIDENTAL, was injury causally related to the death? YES

Where did Injury occur? Winthrop, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? in home (Specify type of place)

Manner of Injury Accidental Fall (How did injury occur?)

Nature of Injury Fracture of Left Hip

While at work? No Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) David C. Dow, M. D.
" " "

(Address) Cambridge, Mass Date 8-25 1967

7 Winthrop Cem. Winthrop, Mass. Place of Burial or Cremation. (City or Town)

DATE OF BURIAL August 29, 1967

8 NAME OF FUNERAL DIRECTOR Ernest Plaggrano

ADDRESS 147 Winthrop St. Winthrop

Received and filed SEP 6 1967 19

John A Clark (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

13 AGE 74 Years 7 Months 22 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Pharmacist (Kind of work done during most of working life)

15 Industry or Business: Drug Store

16 Social Security No. 028-10-7989

17 BIRTHPLACE (City) (State or country) Dorchester New Brunswick

PARENTS

18 NAME OF FATHER Albert Turner

19 BIRTHPLACE OF FATHER (City) (State or country) Dorchester New Brunswick

20 MAIDEN NAME OF MOTHER Eva (c.n.b.l.)

21 BIRTHPLACE OF MOTHER (City) (State or country) Dorchester New Brunswick

22 Informant (Address) Harold E. Driscoll 115 Winthrop St. Winthrop, Mass.

A TRUE COPY

ATTEST: Thomas M. McNamara (Registrar of City or Town where death occurred)

DATE FILED Aug. 29, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers (City or Town making this return)

Registered No. 177

1 PLACE OF DEATH: Essex (County); Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Abraham Pearlstein (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 57 Hutchinson St. Winthrop Mass. (City or town and State)

Length of stay: In place of death ....years 1 months 12 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 13, 1967, to August 25, 1967. I last saw him alive on August 25, 1967, death is said to have occurred on the date stated above, at 3:20a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cardio respiratory failure — hrs.

Due To (b) Arteriosclerotic heart disease — yrs.

Due To (c) Generalized arteriosclerosis — yrs.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus — yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 8/29/67

6 Place of Burial or Cremation: Miskan Tefila (City or Town) West Roxbury

DATE OF BURIAL August 27, 1967

7 NAME OF FUNERAL DIRECTOR Levine Chapel

ADDRESS Brookline, Mass.

Received and filed SEP 6 1967

John A Clare
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of Frances Pearlstein (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 84 Years 1 Months 23 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Foreman (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 011-01-7053-A

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Siron Pearlstein

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Sarah (unknon)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED September 1, 1967

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

M R-303

d for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93631,8

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 178

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)

EN ROUTE TO WINTHROP COMMUNITY HOSPITAL
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ABRAHAM (First Name) BROWN (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. ~~113 SHORE DRIVE~~ WIN. St. ~~WINTHROP~~, MASSACHUSETTS
(Usual place of abode) (If nonresident, give city or town and State)
Summer
PERMANENT RESIDENCE: 164 BELLINGHAM STREET, CHELSEA, MASS.
Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST (Month) 27 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
CORONARY-ARTERY DISEASE

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury .....19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? .....Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Leonard Atkins, M. D.
LEONARD ATKINS, M.D. (Print or Type Name)
(Address) BOSTON, MASS. Date AUG. 27 19 67

7 RABBI ISAAC EICHONIN CEMETERY, EVERETT
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL AUGUST 29 19 67

8 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERVICE, INC.
ADDRESS 151 WASHINGTON AVE., CHELSEA

Received and filed AUG 28 1967 19.....
John A. Clark
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
MALE	WHITE	MARRIED

12 If married, widowed, or divorced
HUSBAND of MOLLIE (RAYMOND)
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE 73 Years 2 Months 10 Days | If under 24 hours .....Hours .....Minutes

14 Usual Occupation: PROPRIETER
(Kind of work done during most of working life)

15 Industry or Business: TAVERN

16 Social Security No. 023-05-1617

17 BIRTHPLACE (City) .....
(State or country) RUSSIA

PARENTS

18 NAME OF FATHER JACOB BROWN

19 BIRTHPLACE OF FATHER (City) .....
(State or country) RUSSIA

20 MAIDEN NAME OF MOTHER ROSE (C.E.L.)

21 BIRTHPLACE OF MOTHER (City) .....
(State or country) RUSSIA

22 Informant MRS. MOLLIE (RAYMOND) BROWN
(Address) 164 BELLINGHAM ST., CHELSEA

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health Aug. 28, 1967
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL .....

DATE OF ENTERING M .....

DATE OF DISCHARGE .....

RANK, RATING ....

ORGANIZATION AND (.....

SERVICE NUMBER ....

.....

Type Copy for State House + for Chelsea - omit Win Shore Dr address - use only Chelsea address per Mr. Klosa 8-29-67

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

I be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 179

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: ANNIE Elizabeth SMITH (Mc Naught) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 30 WILLOW AVE., WINTHROP St. MASS. (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 80 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: August (Month) 27 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 20, 1967, to August 27, 1967. I last saw her alive on August 26, 1967, death is said to have occurred on the date stated above, at 4:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Myocardial infarction	2 days
Due To (b) Arteriosclerotic Heart Disease	1 YR.
Due To (c) Generalized Arteriosclerosis	2 YRS.
OTHER SIGNIFICANT CONDITIONS: Adenocarcinoma of Sigmoid Colon	2 Mos.

Was autopsy performed? No.

What test confirmed diagnosis? Clinical + Lab.

5 Was disease or injury in any way related to occupation of deceased? No. If so, specify

(Signature) M. Traunstein Jr., M. D.

M. TRAUNSTEIN JR. M.D. (Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop, Mass. Date Aug. 27, 1967

6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 30, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed AUG 30 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William Augustus Smith (Husband's name in full)

12 AGE 80 Years 0 Months 10 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation medical secretary (Kind of work done during most of working life)

14 Industry or Business: Physicians office

15 Social Security No. 032-03-3932-A

16 BIRTHPLACE (City) Beachmont (State or country) Massachusetts

PARENTS

17 NAME OF FATHER John McNaught

18 BIRTHPLACE OF FATHER (City) Eastport (State or country) Maine

19 MAIDEN NAME OF MOTHER Annie Armstrong

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Maine

21 Informant William A. Smith

(Address) 30 Willow Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano JR (Signature of Agent of Board of Health or other)

Dir. of Public Health Aug 30 1967

(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investlgate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 180

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Arnold Abbott
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WW #1

(a) Permanent Residence. No. 31 Palmyra St. St. (City or town and State)

Length of stay: In place of death ..years..months 7 days. In place of residence 40 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 30, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1967, to Aug 30, 1967
I last saw him alive on Aug 30, 1967 death is said to have occurred on the date stated above, at 10:13 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Carcinomatosis	
Due To (b) Carcinoma of pancreas ?	3 weeks
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify No

(Signature) H. A. Greenfield, M. D.
H. A. Greenfield (Print or Type Name)
(Address) 447 Winthrop Winthrop Mass. Date 8-30 1967

6 Place of Burial or Cremation Winthrop (City or Town) Winthrop
DATE OF BURIAL September 2, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed SEP 1 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Lillian M Gallagher (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 71 Years..Months..Days. If under 24 hours ..Hours..Minutes

13 Usual Occupation President Munroe Co (Kind of work done during most of working life)

14 Industry or Business: Plumbing Supplies

15 Social Security No. 012-07-7788

16 BIRTHPLACE (City) South Waterford (State or country) Maine

PARENTS
17 NAME OF FATHER William E. Abbott
18 BIRTHPLACE OF FATHER (City) South Paris (State or country) Maine
19 MAIDEN NAME OF MOTHER Mae Barrett
20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Maine

21 Informant Lillian M. Abbott
(Address) 31 Palmyra St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip L. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 9/1/67
(Official Designation) (Date of Issue of Permit)

00M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 6-23-17

DATE OF DISCHARGE 7-21-19

RANK, RATING ..... Sgt

ORGANIZATION AND OUTFIT ..... U.S.Marines

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

...be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 181

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SCOPPETTUOLO, ~~XXXXX~~ LENA (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 31 ST. ANDREW RD. St. EAST BOSTON, MASS. (City or town and State)

Length of stay: In place of death ..... years ..... months 17 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. (Month) 30 (Day) - 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1966, to Aug 30 - 1967

I last saw her alive on Aug 29, 1967 death is said to have occurred on the date stated above, at 7 a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Massive Pulmonary INFARCTION	3 days
Due To (b) Thrombophlebitis of Leg	3 days
Due To (c) Metastatic Carcinoma of Sternum	
OTHER SIGNIFICANT CONDITIONS Radical Mastectomy (Right) 1966 for Carcinoma of Breast	

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify No

(Signature) Charles Meloni, M. D.

CHARLES MELONI (Print or Type Name)

(Address) 45 Bayswater St. Bost., Date Aug 30 1967

6 Holy Cross Cemetery, Malden (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL September 2nd 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed AUG 31 1967 19..

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Single

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 60 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Stitcher (Kind of work done during most of working life)

14 Industry or Business: Awnings

15 Social Security No. 012-07-8013

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Anthony Scoppettuolo

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Italy

19 MAIDEN NAME OF MOTHER Carmela Vitaglino

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Italy

21 Informant Mrs. Madeline Rego-sister

(Address) 31 St. Andrew Rd., E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (McK) (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 8/31/67 (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

AUG 31 '67 PM

OFFICE OF THE TOWN C
WINTHROP, MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Funeral Director: Please use only BLACK ink.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

182

BOSTON (City or Town making this return)

Registered No. ~~06529~~

1 PLACE OF DEATH: SUFFOLK (County) OUT OF TOWN
BOSTON (City or Town)
No. Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME EDNA B. RAMEY (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 74 Birch Road, Winthrop, Mass. St. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 4 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from June 6, 1967, to July 4, 1967

I last saw her alive on July 4, 1967, death is said to have occurred on the date stated above, at 12:10 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) HODGKINS DISEASE	8 MOS.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) [signature], M. D.

(Print or Type Name) Charles L. Clay, M.D.

(Address) Ass't Dir., Mass. Gen'l Hosp Date July 4 1967

6 Winthrop Cemetary Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 8, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed JUL 10 1967 19

William J. Rane (Registrar)

A TRUE COPY ATTEST: OCT 4 1967

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F.

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Herbert F. Ramey (Husband's name in full)

12 AGE 77 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation House Wife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 016-25-8292

16 BIRTHPLACE (City) (State or country) Saulnienville Nova Scotia

PARENTS

17 NAME OF FATHER John Doucette

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Marie Comeau

20 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

21 Informant Mrs John Goll

(Address) 74 Birch Rd. Winthrop Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. P. Graca E 11188
(Signature of Agent of Board of Health or other)

(Official Designation) July 6 1967 (Date of Issue of Permit)

LOOM-8-66-943275

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

A2

FORM R-301A

183

OUT - OF - TOWN

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. ~~06674~~

1 PLACE OF DEATH: Suffolk (County) Jamaica Plain (City or Town)

No. Duplex Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gilbert G. Hewitt (First Name) (Middle Name) Gilbert G. Hewitt (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW1

(a) Residence, No. 19 Moore Street St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 1 months ..... days. In place of residence 30 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7-11-67 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-10-67, 19..., to 7-11-67, 19..., I last saw him alive on 7-10-67, 19..., death is said to have occurred on the date stated above, at 9:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute Dilatation of Heart	18 hours
Due To (b)	Cardiovascular Disease	years
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Pulmonary Emphysema.	

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Elia Calicchio, M. D

Elia Calicchio, M.D (PRINT OR TYPE SIGNATURE)

(Address) 7 Hancock St Boston Date 7-11-67 19..

6 Woodlawn Crematory Everett (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL July 13 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed JUL 13 1967 19..

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 5 Months 27 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Jeweler (Kind of work done during most of working life)

14 Industry or Business: Retail Jewelry

15 Social Security No. 010-03-4929

16 BIRTHPLACE (City) (State or country) Birmingham England

PARENTS

17 NAME OF FATHER Unable to obtain

18 BIRTHPLACE OF FATHER (City) (State or country) Unable to obtain

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City) (State or country) Unable to obtain

21 Informant (Address) Janet S Howard 19 Moore St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature] (Signature of Agent of Board of Health or other)

911366 (Official Designation) July 11, 1967 (Date of Issue of Permit)

OCT 4 1967

100M-6-60-928145

A TRUE COPY ATTEST!

William J. Kane.

City Registrar

OCT 4 '67 AM

OFFICE OF THE TOWN CLE
WA[illegible] MASS.

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 41-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

184

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

BOSTON (City or Town making this return)

Registered No. ~~06758~~

No. 974 Saratoga St., East Boston St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: PATRICK (First Name) FOLEY (Last Name) (Middle Name) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 40 Sunnyside Ave St. Winthrop Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 20 years – months – days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: July (Month) 12, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.

Michael A. Luongo, M.D. (Print or Type Name)

(Address) Boston Date 7/12 19 67

7 Place of Burial or Cremation: WINTHROP (City or Town) WINTHROP

DATE OF BURIAL JULY 14 19 67

8 NAME OF FUNERAL DIRECTOR: MAURICE W. KIRBY

ADDRESS 210 WINTHROP ST. WINTHROP

Received and filed JUL 14 1967 19.....

A TRUE COPY ATTEST: (Registrar) OCT 4 1967

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male

10 COLOR: white

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): SINGLE

12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 65 Years – Months – Days. If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Manutance (Kind of work done during most of working life)

15 Industry or Business: BAR AND GRILL

16 Social Security No. not Known

17 BIRTHPLACE (City) (State or country) EAST BOSTON

PARENTS

18 NAME OF FATHER: JAMES PATRICK FOLEY

19 BIRTHPLACE OF FATHER (City) (State or country) EAST BOSTON

20 MAIDEN NAME OF MOTHER: MARY E O'DONNELL

21 BIRTHPLACE OF MOTHER (City) (State or country) EAST BOSTON

22 Informant (Address): JAMES L. FOLEY 40 SUNNYSIDE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F P Graca E/1 4 E/2 (Signature of Agent of Board of Health or other)

(Official Designation) July 14, 1967 (Date of Issue of Permit)

MEDICAL

A TRUE COPY ATTEST:

William J. Kane

City Registrar

TOWN CLERK
MASS.
OCT 4 '67 AM

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

185

Danvers
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Essex (County); Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Doris Levy (Rubenstein)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 45 Grovers Avenue xx Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 5 years 5 months 1 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 28, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 27, 1962, to August 28, 1967, I last saw her alive on August 28, 1967, death is said to have occurred on the date stated above, at 8:30a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary infarct	mins.
Due To (b) Arteriosclerotic heart disease	yrs.
Due To (c) Generalized arteriosclerosis	yrs.
OTHER SIGNIFICANT CONDITIONS Diabetes mellitus	yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical&Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 8/29/67, 19

6 Place of Burial or Cremation: Staro Konstantino W.Roxbury (City or Town)

DATE OF BURIAL August 29, 19 67

7 NAME OF FUNERAL DIRECTOR Levine Chapel, Inc.

ADDRESS Brookline, Mass.

Received and filed SEP 14 1967, 19

John A Clar
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Samuel Levy
(Husband's name in full)

12 AGE 83 Years 7 Months 25 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 010-03-0749

16 BIRTHPLACE (City) ..... (State or country) Lithuania

PARENTS

17 NAME OF FATHER Ephraim Rubenstein

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Russia

19 MAIDEN NAME OF MOTHER Fannie Klenovich

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Russia

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY Daniel J. Toomey
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED September 1, 19 67

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 186

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. 49 HUTCHINSON ST St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: ROSE [illegible] BRAFF
(If deceased [illegible], widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 49 HUTCHINSON St. WINTHROP (City or town and State)

Length of stay: In place of death 45 years ..... months ..... days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Sept (Month) / (Day) / 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1952, to Sept 1, 1967

I last saw her alive on Aug. 31, 1967, [illegible] death is said to have occurred on the date stated above, at 2:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypertensive ARTERIOSCLEROTIC	
Due To (b) HEART DISEASE	15 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 9/1/ 1967

6 BETH DAVID, WOBURN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL SEPT. 3 1967

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV. INC.
ADDRESS 151 WASHINGTON AVE., CHELSEA

Received and filed SEP 6 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of SAMUEL BRAFF
(Husband's name in full)

12 AGE 77 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER MEYER ROSS

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER C. B. L.

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MRS MARION LAUB
(Address) 49 HUTCHINSON ST., WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 9/2/67
(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
OR CAUSES
DEATH

not enter
nre than one
se for each
), (b) and (c)

h does not mean
ode of dying,
heart failure,
, etc. It means
ease, or compli-
which caused
h

ditions, if any,
h gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
death but not
to the terminal
condition given
a

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 187

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marion A. Merrill (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 26 Faun Bar Avenue St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years 1 months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 20, 1967, to Sept 1, 1967

I last saw her alive on August 30, 1967, death is said to have occurred on the date stated above, at 6:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia terminal	2 days
Due To (b) Carcinoma of Breast	1 yr
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerosis gen.	yrs.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) [illegible], M. D.

[illegible]
(Print or Type Name)

(Address) Winthrop Mass. Date Sept 1 1967

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 5, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed SEP 5 1967 19

John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: single

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 93 Years 9 Months 16 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Christian Science Reader (Kind of work done during most of working life)

14 Industry or Business self employed

15 Social Security No. 033-26-5689-A

16 BIRTHPLACE (City) Hinckley (State or country) Illinois

PARENTS

17 NAME OF FATHER Francis E. Merrill

18 BIRTHPLACE OF FATHER (City) Washington (State or country) D.C.

19 MAIDEN NAME OF MOTHER (unknown) Costler

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) U.S.A.

21 Informant Harry A. Saunders, Adm.

(Address) 259 Beacon St. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitaglianos
(Signature of Agent of Board of Health or other)

Director of Public Health 9/5/67
(Official Designation) (Date of Issue of Permit)

-63-936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 5 '67 AM

OFFICE OF THE TOWN
WINTHROP, MASS

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 188

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)
No. ..... St.

2 FULL NAME HARRY BROWN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 26 FORREST STREET St. WINTHROP, MASS
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 21 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 5 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1967 to Sept 5, 1967
I last saw him alive on Sept 5, 1967 death is said to have occurred on the date stated above, at 12.07 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Pulmonary embolism — 7 days
Due To
(b) arteriosclerosis
Due To
(c) Diabetes, Arterial

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OTHER SIGNIFICANT CONDITIONS Diabetes, arterial hypertension - Angina

Was autopsy performed? no
What test confirmed diagnosis? X-Ray

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signature) H. B. Greenfield, M. D.
(Print or Type Name)
(Address) 447 Shirley St Winthrop Date Sept 5 1967

6 IND. PRIDE OF BOSTON West Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL SEPTEMBER 7 1967

7 NAME OF FUNERAL DIRECTOR LEVINE CHAPEL
ADDRESS 470 HARVARD ST. BROOKLINE

Received and filed SEP 5 1967 19....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
MALE	WHITE	MARRIED

11 If married, widowed, or divorced HUSBAND of BESSIE KAPLAN
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 75 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation SALESMAN
(Kind of work done during most of working life)

14 Industry or Business: MACHINERY

15 Social Security No. 079-40-1876

16 BIRTHPLACE (City) BOSTON (State or country) MASS.

PARENTS
17 NAME OF FATHER HYMAN BROWN
18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA
19 MAIDEN NAME OF MOTHER SARAH (UNKNOWN)
20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MRS. BESSIE BROWN
(Address 26 FORREST ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip D. Vitaliano M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health 9/5/67
(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 5 '67 P

OFFICE OF THE TOWN
WINTHROP, MAS

FORM R-301

-d for burial permit
-ard of Health
Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
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se for each
), (b) and (c)

does not mean
ode of dying,
s heart failure,
ea, etc. It means
ease, or compli-
which caused

itions, if any,
h gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 189

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 170 Cliff Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number) Cliff House Nursing Home

PHYSICIAN — IMPORTANT

2 FULL NAME: ANNA TATELMAN (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 131 Spruce St St. Chelsea (Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 10 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: SEPT. (Month) 5, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 30, 1967, to SEPT 5, 1967

I last saw her alive on SEPT 4, 1967, death is said to have occurred on the date stated above, at 7.30 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CARDIAC DECOMPENSATION	1967
Due To (b) ARTERIOSCLEROTIC HEART DIS.	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: CARCINOMATOSIS PRIMARY LEFT BREAST	1952

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) A N Caplan, M. D.
A. N. CAPLAN MD
(Print or Type Name)
(Address) 186 PRINCETON ST E. BOSTON Date 9-5 1967

6 AGUDOS ACHIM MELROSE
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 6 1967

7 NAME OF FUNERAL DIRECTOR TORF Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed SEP 6 1967 19

John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Fem

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOW

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ISAAC TATELMAN (Husband's name in full)

12 AGE 70 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: AT Home

15 Social Security No. 014-20-3193

16 BIRTHPLACE (City) (State or country): Russia

PARENTS

17 NAME OF FATHER: SAMUEL KRICHMAR

18 BIRTHPLACE OF FATHER (City) (State or country): Russia

19 MAIDEN NAME OF MOTHER: Bessie C B.L.

20 BIRTHPLACE OF MOTHER (City) (State or country): Russia

21 Informant: Bessie Tatelman
(Address) 131 Spruce St Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 9/6/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Chelsea notified 10-9-67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 6 '67 AM

OFFICE OF THE TOWN CL
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 190

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town) No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph Young
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 131 Union St St. Lynn (City or town and State)

Length of stay: In place of death ..years..months 21 days. In place of residence 62 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Aug 23, 1967, to Sept 5, 1967
I last saw him alive on Aug 31, 1967, death is said to have occurred on the date stated above, at 12:05 Noon m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary Thrombosis	minutes
Due To (b)	Arteriosclerosis-gen	yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Robinson's Disease	yrs

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregoire, M. D.
Joseph GREGORIE (Print or Type Name)
(Address) 194 Washington St Date 9/5 1967

6 Pine Grove Lynn
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 7 1967

7 NAME OF FUNERAL DIRECTOR W. C. Parker
ADDRESS Lynn Mass

Received and filed SEP 6 1967
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M
9 COLOR: W
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 80 Years. 1 Months 18 Days | If under 24 hours ..Hours ..Minutes

13 Usual Occupation Ticket Agent
(Kind of work done during most of working life)

14 Industry or Business B. & M. R.R.

15 Social Security No. 010-16-9599

16 BIRTHPLACE (City) Ipswich (State or country) Mass.

PARENTS

17 NAME OF FATHER Ambrose Young

18 BIRTHPLACE OF FATHER (City) Digby (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Mary McPhail

20 BIRTHPLACE OF MOTHER (City) River Dennis (State or country) Cape Breton Canada

21 Informant Alice Walfield
(Address) 67 Jackson St. Lynn

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip H. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 9/6/67
(Official Designation) (Date of Issue of Permit)

100M-5-64-938000

A TRUE COPY ATTEST:

gNN - 10-9-67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 6 1
OFFICE OF THE T
WINTHROP,

FORM R-301

:d for burial permit
Board of Health
- its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
:. OR CAUSES
' DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
, etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

52-933404

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 191

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 4 Highland Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Alfred Howard Bagness
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 4 Highland Ave St. (City or town and State)
(Usual place of abode)

Length of stay: In place of death 30 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT. (Month) 6 (Day), 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1955, to SEPT. 6, 1967
I last saw him alive on SEPT. 5, 1967, death is said to have occurred on the date stated above, at 9:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) ARTERIOSCLEROTIC HEART DISEASE — 4 MOS.
Due To (b) Pulmonary bronchitis & EMPHYSEMA — 12 yrs
Due To (c)
OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS — 9 MOS.

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) M. Traunstein Jr. M. D.
M. TRAUNSTEIN JR. MD
(Print or Type Name)
(Address) 73 Bartlett Rd Winthrop, Mass. Date Sep 6, 1967

6 Winthrop — Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 9 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass.

Received and filed SEP 8 1967 19....
John A Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Ruth (Day) Bagness
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 60 Years 10 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Superintendent
(Kind of work done during most of working life)

14 Industry or Business: Manufacture Brass Products

15 Social Security No. 031-01-3623

16 BIRTHPLACE (City) Winthrop (State or country) Mass.

PARENTS
17 NAME OF FATHER Alfred T Bagness
18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.
19 MAIDEN NAME OF MOTHER Louisa Baxter
20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Ruth Bagness
(Address) 4 Highland Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)
Dir. of Public Health
(Official Designation)
9/8/67
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-304

5M-6-60-928241

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with Board of Health or its Agent.

Registered No. 192

1 PLACE OF DELIVERY
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 NAME OF FETUS (if given) O'CONNELL FEMALE

3 DATE OF DELIVERY 9/7/67 (Month) (Day) (Year)

4 SEX Male Female X Undetermined

5 COLOR (if determined) WH

6 THIS BIRTH (Check one) Single Twin Triplet

7 IF MULTIPLE BIRTH, BORN: 1st 2nd 3rd

FATHER

8 FULL NAME KEVIN O'CONNELL

9 RESIDENCE, NO. 27 CHELSEA STREET
CITY OR TOWN EAST BOSTON STATE MASS

10 COLOR OR RACE WHITE

11 AGE AT TIME OF THIS DELIVERY 20 (Years)

12 PLACE OF BIRTH BOSTON, MASS (City or Town) (State or country)

13 OCCUPATION SHIPPER

MOTHER

14 MAIDEN NAME HELEN HALL
PRESENT NAME HELEN O'CONNELL

15 RESIDENCE, NO. 27 CHELSEA STREET
CITY OR TOWN EAST BOSTON STATE MASS

16 COLOR OR RACE White

17 AGE AT TIME OF THIS DELIVERY 22 (Years)

18 PLACE OF BIRTH WINTHROP, MASS (City or Town) (State or country)

19 INFORMANT HELEN O'CONNELL

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus) 1

(a) How many children are now living? 1

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY 36 completed weeks

22 WEIGHT OF FETUS 2 Lb. 10 Oz. (or Grams)

23 WHEN DID FETUS DIE? Before Labor ✓ During Labor or Delivery and 7 MO Unknown

24 AUTOPSY Yes No ✓

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) ANENCEPHALIC and
Due To (b) HYDRAMNIOS CAUSE
Due To (c) UNDETERMINED

OTHER SIGNIFICANT CONDITIONS NONE

26 Place of Burial or Cremation Winthrop (City or Town) Winthrop
DATE OF BURIAL 9-8-67 1967

27 NAME OF FUNERAL DIRECTOR Maurice G. Kirby
ADDRESS 210 Winthrop St.

Received and filed September 7, 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 9:20 A.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
Myron N. King M.D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
Address 22 PLEASANT ST. WINTHROP MASS Date 9/7/67

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 9/7/67
(Official Designation) (Date of Issue of Permit)

In giving CAUSE OF TAL DEATH

lo not enter ore than one use for each of (a), (b) and (c)

al or maternal dition causing l death (do use such s as stillbirth rematurity.)

l and/or ma- al conditions, y, which gave to above e (a), stating underlying e last.

litions of fetus nother which have contrib- d to fetal h, but, in so as is known, not related ause given a).

Lynn E B. 10-9-67

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48, ACTS OF 1960.

*Section 2*A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

*Section 9*A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean he mode of dying, uch as heart failure, sthenia, etc. It means he disease, or compli- ations which caused leath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ting to death but not elated to the terminal isease condition given n (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 193

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 34 Hawthorn Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edith Fishman (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 380 Shirley St. St. Winthrop (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 13 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from SEPT. 25, 1966, to SEPT. 13, 1967, I last saw her alive on SEPT. 4, 1967 death is said to have occurred on the date stated above, at 9 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL ARTERIAL THROMBOSIS	3 yrs
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS PARALYSIS OF LOWER EXTREMITIES	2 yrs

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL COURSE

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myer Fishman, M. D.
Myer Fishman, M.D.
(Print or Type Name)
(Address) 483 Beacon St. Boston, Mass. Date 9/13 1967

6 Beth Israel of Cambridge, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 14 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed SEP 14 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Dr. Hyman Fishman (Husband's name in full)

12 AGE 68 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation House-wife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) cnbl Rumania

PARENTS

17 NAME OF FATHER Samuel Baratt

18 BIRTHPLACE OF FATHER (City) (State or country) cnbl Rumania

19 MAIDEN NAME OF MOTHER Fay (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) cnbl Rumania

21 Informant Leonard Rosenberg
(Address) 34 Hawthorne Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir of Public Health Sept 14 1967
(Official Designation) (Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301

RUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 194

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARGUERITE M. HICKEY (Doherty) (First Name) (Middle Name) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 207 Bellingham Avenue St. Revere (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 22 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 15, 1967, to Sept 14, 1967

I last saw her alive on Sept. 14, 1967, death is said to have occurred on the date stated above, at 10:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Ca. of Pancreas	3 months
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS --	

Was autopsy performed? no

What test confirmed diagnosis? Exploratory Laparotomy June 21, 1967

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John F. Collins MD, M. D.

John F. Collins, (Print or Type Name)

(Address) 27 Bennington St. Revere, Mass. Date Sept. 15, 1967

6 Woodlawn Everett (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL 9/18/67 19

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS Revere, Mass.

Received and filed SEP 15 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
Female	White	YES ☒ NO ☐	SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of George H. Hickey (Husband's name in full)

12 DATE OF BIRTH 12/1/02

13 AGE 64 Years 9 Months 13 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 021-10-8237

17 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

18 NAME OF FATHER Michael Doherty

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER Ellen Doherty (ok)

21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant George M. Hickey (Address) 207 Bellingham Av., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Signature of Agent of Board of Health or other)

Dir of Public Health 9/15/67 (Official Designation) (Date of Issue of Permit)

3-930213

REVERE 10-9-67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

UCTIONS
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Refer to Board of Health by Medical Examiner

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 195

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josephine Nasta (Cenci) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 965 Saratoga St. East Boston St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ___ years 4 months ___ days. In place of residence 5 years ___ months ___ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept (Month) 14, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ___, 19__, to ___, 19__

I last saw h__alive on ___, 19__, death is said to have occurred on the date stated above, at 8:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes. Patient

Due To (b) known to be ill with metastatic mucinous carcinoma

Due To (c) WINTHROP BOARD OF HEALTH Charles Liberman M.D.

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles Liberman, M. D.

(Address) WINTHROP, MASS Date 9/14/ 1967

6 Holy Cross Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 18 1967

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. E.B.

Received and filed SEP 15 1967 19__

John Allan (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of ___ (Give maiden name of wife in full)

(or) WIFE of Alphonso Nasta (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 57 Years ___ Months ___ Days

If under 24 hours ___ Hours ___ Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) New York (State or country)

PARENTS

17 NAME OF FATHER Vincent Cenci

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Philomena DiBenedetto

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Alphonso Nasta (Address) 965 Saratoga St. E.B.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B) (Signature of Agent of Board of Health or other)

Dir. of Public Health 9/15/67 (Official Designation) (Date of Issue of Permit)

50M-1-58-921876

E B. 10-9-67

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... .— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 196

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME CHRISTINE McISAAC (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 75 WOODSIDE AVE St. WINTHROP (City or town and State)

Length of stay: In place of death 34 yrs. years ..... months ..... days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 15, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from DEC 3, 1966, to SEPT 15, 1967

I last saw her alive on SEPT 14, 1967 death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CARDIAC DECOMPENSATION	1 YR.
Due To (b) ARTERIOSCLEROSIS-GENERALIZED	—
Due To (c)	
OTHER SIGNIFICANT CONDITIONS CHRONIC NEPHRITIS	1 YR

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) A N Caplan, M. D.
A. N. CAPLAN MD
(Print or Type Name)

(Address) 18 PRINCETON ST E. BOSTON Date 9/15 1967

6 Winthrop Cem Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 18, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed SEP 15 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 84 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOME (Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. 025-26-9727

16 BIRTHPLACE (City) (State or country) NOVA SCOTIA

PARENTS

17 NAME OF FATHER HUGH McISAAC

18 BIRTHPLACE OF FATHER (City) (State or country) NOVA SCOTIA

19 MAIDEN NAME OF MOTHER FLORENCE (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) (State or country) NOVA SCOTIA

21 Informant MRS FLORENCE HANNAFORD

(Address) 75 WOODSIDE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (McK.)
(Signature of Agent of Board of Health or other)

Director of Public Health 9/15/67
(Official Designation) (Date of Issue of Permit)

OOM-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Voter - 170 Cliff Ave

FORM R-301

e filed for burial permit ith Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ians which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ng to death but not lated to the terminal ease canditian given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 197

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Agnes MacLennan (McKie)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 104 Tafts Ave. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 1 years 21 months days. In place of residence 9 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT (Month) 20 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from June 6, 1961, to SEPT 20, 1967
I last saw he alive on SEPT 20, 1967, death is said to have occurred on the date stated above, at 3:48 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 1/2
Due To (b) ARTERIO-SCLEROTIC HEART DISEASE — 6 YRS
Due To (c) NEPHROSCLEROSIS

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No.
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING (M.D.)
(Print or Type Name)
(Address) 22 PLEASANT WINTHROP MASS Date 9/20 1967

6 Place of Burial or Cremation Newton Cemetery (City or Town) Newton
DATE OF BURIAL Sept. 22 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed SEP 21 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Duncan A MacLennan
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 84 Years 0 Months 18 Days — If under 24 hours Hours Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 032-14-4005

16 BIRTHPLACE (City) (State or country) Scotland

PARENTS
17 NAME OF FATHER Ferdinand McKie
18 BIRTHPLACE OF FATHER (City) (State or country) Scotland
19 MAIDEN NAME OF MOTHER Isabella Kelso
20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant Alice M MacLennan
(Address) 14 Oakland Ave. Auburndale,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaghano
(Signature of Agent of Board of Health or other)
Dir of Public Health 9/21/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
oard of Health
its Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
DR CAUSES
DEATH

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than one
for each
)(b) and (c)

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of dying,
heart failure,
etc. It means
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hich caused

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have rise to
cause (a),
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cause last.

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death but not
the terminal
dition given

)-6-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 198

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 15 Thornton Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Winnifred Wallcott Powell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 15 Thornton Street St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 20 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 10:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
Due To (b) to natural causes.
Due To (c) Winthrop Board of Health

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 9/27/1967

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 27, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed SEP 27 1967
John A Clerk
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of William A. Powell
(Husband's name in full)

12 AGE 76 Years 4 Months 15 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired bookeeper
(Kind of work done during most of working life)

14 Industry or Business Winthrop Savings Bank

15 Social Security No. 025-26-4477

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Wilfred Wallcott

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Rebecca Wilder

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Carl Lindsey
(Address) 119 Chestnut St. Andover

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir of Public Health 9/27/67
(Official Designation) (Date of Issue of Permit)

Medical examiner notified — referred to Board of Health

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 27 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 199

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Grace Gavin (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 10 Surfside Avenue St. Winthrop (City or town and State)

Length of stay: In place of death ....years ....months 27 days. In place of residence 5 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 21, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1965, to Sept. 21, 1967

I last saw her alive on Sept. 21, 1967, death is said to have occurred on the date stated above, at 3:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Breast

Due To (b) with generalized

Due To (c) metastesis.

OTHER SIGNIFICANT CONDITIONS None.

INTERVAL BETWEEN ONSET AND DEATH 6 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical, Surgical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS. Date 9/21/1967

6 WINTHROP (Place of Burial or Cremation) WINTHROP (City or Town)

DATE OF BURIAL SEPT 25 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP, MASS.

Received and filed SEPT 25 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: MARRIED

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of MICHAEL P GAVIN (Husband's name in full)

12 AGE 54 Years ....Months ....Days. If under 24 hours ....Hours ....Minutes

13 Usual Occupation TELLER (Kind of work done during most of working life)

14 Industry or Business: BANKS

15 Social Security No.

16 BIRTHPLACE (City) WORCESTER, (State or country) MASS

PARENTS

17 NAME OF FATHER ALEXANDER GIBSON

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER ANNA DROLIN

20 BIRTHPLACE OF MOTHER (City) NORTH GRAFTON (State or country) MASS.

21 Informant PATRICIA GAVIN

(Address) 10 SURFSIDE AVE WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaghano M.D. (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 9/25/67 (Date of Issue of Permit)

100M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 200

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: Alter Gudowsky
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 7 Nazing Court St. Roxbury (City or town and State)

Length of stay: In place of death ..years..months 29 days. In place of residence 12 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Sept. (Month) 27 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1967, to 9/27/, 1967

I last saw him alive on 9/26/, 1967, death is said to have occurred on the date stated above, at 12:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cancer Lung, right, bronchiogenic,	5 months
Due To (b)		
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	NONE	

Was autopsy performed? No

What test confirmed diagnosis? Clinical /

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 9/27/ 1967

6 Place of Burial or Cremation: Sharon Memorial Park, Sharon (City or Town)

DATE OF BURIAL: Sept 29 1967

7 NAME OF FUNERAL DIRECTOR: Benjamin Birnbach

ADDRESS: 1505 Blue Hill Ave. Mattapan

Received and filed SEP 27 1967 19..

John Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: white

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced, HUSBAND of: Fannie Forman (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE: 86 Years 11 Months 15 Days — If under 24 hours ..Hours..Minutes

13 Usual Occupation: Clothing Manufacturer (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 033-26-4067A

16 BIRTHPLACE (City) (State or country): Russia

PARENTS

17 NAME OF FATHER: ISAAC GUDOWSKY

18 BIRTHPLACE OF FATHER (City) (State or country): Russia

19 MAIDEN NAME OF MOTHER: Unknown

20 BIRTHPLACE OF MOTHER (City) (State or country): Russia

21 Informant: Mrs John M. Adamson

(Address) 91 Riverside Circle, Marshfield

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaghano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 9/27/67
(Official Designation) (Date of Issue of Permit)

OM-8-66-943275

Boston - 10-9-67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 27 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

o be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 201

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LEO W PELLETIER (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 33 ATLANTIC STREET St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 29, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from OCT, 1965, to SEPT 29, 1967

I last saw him alive on 9/28, 1967, death is said to have occurred on the date stated above, at 7:50 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE CORONARY OCCLUS.	1 HR.
Due To (b) ARTERIOSCEROTIC HEART DIS	3 YRS
Due To (c) MYOCARDIAL ISCHEMIA	3 YRS
= SUPERENDOCARDIAL NECROSIS	2 WKS.
OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS	3 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL & EGK.

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron N. King, M. D.

MYRON N. KING MD
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date SEPT 29 1967

6 New Calvary Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 2, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed OCT 2 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWER

11 If married, widowed, or divorced HUSBAND of Mary M. O'Connell (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 65 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Bookbinder (Kind of work done during most of working life)

14 Industry or Business Printing

15 Social Security No. 010-03-8146

16 BIRTHPLACE (City) (State or country) Canada

PARENTS

17 NAME OF FATHER Ovide Pelletier

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Rose Gueret

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Leo W. Pelletier Jr.

(Address) 3 Francis Road Lexington, Ma

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 10/2/67
(Official Designation) (Date of Issue of Permit)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

A2

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or complications which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not ated to the terminal ease condition given (a).

420.1
81
70

Funeral Director: lease use only BLACK ink.

OCT 27 1967

C-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

202

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

Boston (City or Town making this return)

Registered No. ~~[illegible]~~

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hallahan James Hallahan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W. W. 1

(a) Permanent Residence. No. 504 Bennington St Boston Mass St. (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29 1967 (Month) (Day) (Year)

I HEREBY CERTIFY, that I was attended deceased from 6/20/67, 19..., to July 29 1967, 19..., we last saw him alive on July 29 1967, 19..., death is said to have occurred on the date stated above, at 12/15 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	days
Due To (b) Fracture of left hip	1 month
Due To (c) Osteopourosis	years
OTHER SIGNIFICANT CONDITIONS Coronary heart disease	years

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date July 29 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1, 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS East Boston

Received and filed AUG 1 1967 19..

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) married

11 If married, widowed, or divorced HUSBAND of Margaret A. Treanor (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 86 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Stationery Engineer (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 021-12-1735

16 BIRTHPLACE (City) (State or country) New York

PARENTS

17 NAME OF FATHER William Hallahan

18 BIRTHPLACE OF FATHER (City) (State or country) New York

19 MAIDEN NAME OF MOTHER CNBL Applegate

20 BIRTHPLACE OF MOTHER (City) (State or country) New York

21 Informant Margaret Hallahan

(Address) 504 Bennington St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Eugene Leonard 11958
(Signature of Agent of Board of Health or other)

(Official Designation) July 30 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67 AM

OFFICE OF TOWN CLERK
WIN

OUT = OF - TOWN

203

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Boston (City or Town making this return)

Registered No. ~~[illegible]~~

1 PLACE OF DEATH: Suffolk (County); Jamaica Plain (City or Town); No. Lemuel Shattuck Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ruth Beaton (~~Hall~~) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 2 Highland Ave., Winthrop (City or town and State)

Length of stay: In place of death ..years 1 months ..days. In place of residence 4 years 2 months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7/6, 1967, to 8/5, 1967. I last saw him alive on 8/5, 1967, death is said to have occurred on the date stated above, at 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia

Due To (b) Multiple myeloma

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) H. Thum, M. D.

Hans Thum (Print or Type Name)

(Address) Lemuel Shatt. Hosp. Date 8/5 1967

6 Place of Burial or Cremation: Puritan Lawn (City or Town) Peabody

DATE OF BURIAL August 9. 1967 19..

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere

Received and filed AUG 10 1967 19..

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of John Beaton (Husband's name in full)

12 AGE 71 Years 9 Months 4 Days; If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No.

16 BIRTHPLACE (City) Bay City (State or country) Michigan

PARENTS

17 NAME OF FATHER: Horace G. Hall

18 BIRTHPLACE OF FATHER (City) Bay City (State or country) Michigan

19 MAIDEN NAME OF MOTHER: Nettie Greenfield

20 BIRTHPLACE OF MOTHER (City) Bay City (State or country) Michigan

21 Informant: John Beaton

(Address) 2 Highland Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. S. Lacca C13573 (Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Aug. 8 1967

203 55 17

OCT 27 1967

M-8-66-943275

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67 AM

OFFICE OF TOWN CLERK
WINTHROP, MASS

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

204

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

1 PLACE OF DEATH: SUFFOLK (County) ROXBURY (City or Town)

Boston (City or Town making this return)

Registered No. [illegible]

No. JEWISH MEMORIAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNA WALLACE KUSHNER (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 43 OCEAN AVENUE St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death ..... years ..... months 48 days. In place of residence 18 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 12 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3 July, 1967, to 12 August, 1967. I last saw her alive on 12 August, 1967, death is said to have occurred on the date stated above, at 9 00/A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Grade III Astrocytoma of Right

Due To (b) Cerebral hemisphere

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? NO

What test confirmed diagnosis? Surgery

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Alberta Kathleen Brough M.D., M. D.
Alberta KATHLEEN BROUGH M.D.
(Print or Type Name)
(Address) 59 TOWNSEND STREET Date 12 August 1967

6 Kamingker, West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 13, 1967

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St., Brookline

Received and filed AUG 15 1967 19

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Joseph Kushner (Husband's name in full)

12 AGE 63 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Gloucester, Mass.

PARENTS

17 NAME OF FATHER Abraham Wallace

18 BIRTHPLACE OF FATHER (City) (State or country) Unknown

19 MAIDEN NAME OF MOTHER Eva (Unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

21 Informant Joseph Kushner

(Address) 43 Ocean Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Robert J. Spanish
(Signature of Agent of Board of Health or other)

E12426 (Official Designation) 8/12/67 (Date of Issue of Permit)

193
5
X

OCT 27 1967

100M-9-65-941327

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67

OFFICE OF TOWN CLERK
WIN

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

205

Brighton
(City or Town making this return)

Registered No. 1363

PLACE OF DEATH

1 Suffolk (County)

Brighton (City or Town)

No. St. John of God Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur Allison Rolfe
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. (Usual place of abode) No. 21 Harbor View Avenue St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 1 years 3 months 17 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 12, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4/25, 1966, to 8/12/67, 19..., I last saw him alive on 8/12/67, and, death is said to have occurred on the date stated above, at 8:15P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Retroperitoneal Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 2/15/66

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? None

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) John A. Bolzan, M. D.
John A. Bolzan (Print or Type Name)
(Address) 296 Allston St. Brookline, Mass. Date 8-12 1967

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Aug. 16 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS East Boston

Received and filed AUG 17 1967 19...
William J. Hare (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Josephine Bright
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 59 Years. 3 Months. 12 Days. If under 24 hours .. Hours .. Minutes

13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business retired

15 Social Security No. 030-20-0395

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Fenwick Rolfe

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia, Canada

19 MAIDEN NAME OF MOTHER Mary Duffy

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Massachusetts

21 Informant Josephine Rolfe
21 Harbor View Ave. Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F.P. Graca C.H.E.P.S.
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Aug 15, 1967

199
57
X71

OCT 27 1967

100M-9-63-936348

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67 AM

OFFICE OF TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

206

Boston (City or Town making this return)

Registered No. [illegible]

1 PLACE OF DEATH: Suffolk (County); BOSTON (City or Town)

No. BOSTON HOSPITAL FOR WOMEN LYING-IN DIVISION St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: BABY BOY RANDAZZO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 59 CREST AVE St. WINTROP (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: AUGUST (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at .....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) PETECHIAL LUNG HEMORRHAGES	7 hrs
Due To (b) MARKED PREMATURITY (650 gms)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: CONGENITAL OBLITERATION, (L) URETER	

Was autopsy performed? YES

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify NO

(Signature) ROSEMARY LEAKE Rosemary Leake, M. D.
ROSEMARY LEAKE (Print or Type Name)

(Address) 100 SUMMER ST. WESTON Date 8/16/1967

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)

DATE OF BURIAL August 17 1967

7 NAME OF FUNERAL DIRECTOR: F. J. Magrath

ADDRESS: East Boston

Received and filed AUG 15 1967 19.....

William J Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE.....Years.....Months.....Days — If under 24 hours: 7 Hours 0 Minutes

13 Usual Occupation ..... (Kind of work done during most of working life)

14 Industry or Business .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country): BOSTON, MASS

PARENTS

17 NAME OF FATHER: ROBERT J. RANDAZZO, JR

18 BIRTHPLACE OF FATHER (City) (State or country): EVERETT, MASS

19 MAIDEN NAME OF MOTHER: ROSE P. LYNCH

20 BIRTHPLACE OF MOTHER (City) (State or country): BOSTON, MASS

21 Informant: BOSTON HOSPITAL FOR WOMEN

(Address) 221 Longwood Ave, Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Eugene Leonard E 12549
(Signature of Agent of Board of Health or other)

(Official Designation) August 16 1967 (Date of Issue of Permit)

776/135

OCT 27 1967

100M-12-62-934553

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

to be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

331
70

Funeral Director: Please use only BLACK ink.

OCT 27 1967

LOOM-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

207

Boston (City or Town making this return)

Registered No. [illegible]

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: CHARLES C. Edward Magoon (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 233A Woodside Ave - Winthrop Mass (City or town and State)

Length of stay: In place of death ..... years ..... months 16 hrs. days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: August (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from August 18, 1967, to August 19, 1967. I last saw him alive on August 19, 1967, death is said to have occurred on the date stated above, at 7:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral Edema	Hours
Due To (b)	Cerebral Hemmorhage	Hours
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. Clay, M. D.

(Print or Type Name) Charles L. Clay, M.D.

(Address) Ass't Dir., Mass. Gen'l Hosp. Date 8-19 1967

6 Glenwood Cemetery, Littleton, N.H. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 22, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS Winthrop

Received and filed AUG 1967 19

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Gertrude T. Magoon (Richardson) (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 65 Years 1 Months 6 Days — If under 24 hours Hours Minutes

13 Usual Occupation V.P. H.W. Peabody Associates (Kind of work done during most of working life)

14 Industry or Business: Importers

15 Social Security No. 001-12-7886

16 BIRTHPLACE (City) Manchester (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Charles Edward Magoon

18 BIRTHPLACE OF FATHER (City) Derby Line (State or country) Canada

19 MAIDEN NAME OF MOTHER Georgia Ida Southard

20 BIRTHPLACE OF MOTHER (City) Manchester (State or country) New Hampshire

21 Informant Wife Gertrudge

(Address) 233A Woodside Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Eugene Tronad E 12673 (Signature of Agent of Board of Health or other)

(Official Designation) Aug 21 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '67 AM

OFFICE OF TOWN CLERK
WINTHROP, MASS

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Malden 208
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Malden (City or Town)

No. Malden Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Goodman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 25 Moore St. St. Winthrop (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 1, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1967, to Sept. 30, 1967

I last saw him alive on Sept. 30, 1967 death is said to have occurred on the date stated above, at 11:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cardio Vascular Sclerosis — 5 mos.

Due To (b) .....

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS .....

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased no

If so, specify .....

(Signature) Abraham Bloom, M. D.

(Address) 217 Cross St. Malden, Mass. Date 10-1 1967

Place of Burial or Cremation: Kopaigorod Cemetery West Roxbury (City or Town)

DATE OF BURIAL Oct. 2, 1967

7 NAME OF FUNERAL DIRECTOR Murray Goldman

ADDRESS 174 Ferry St. Malden, Mass.

Received and filed OCT 4 1967 19....

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M.

9 COLOR: W.

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Wid.

11 If married, widowed, or divorced HUSBAND of Fannie (unknown)
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 AGE 84 Years 3 Months 17 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Merchant
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 032-05-7824

16 BIRTHPLACE (City) Unknown (State or country) Russia

PARENTS

17 NAME OF FATHER Samuel Goodman

18 BIRTHPLACE OF FATHER (City) - (State or country) Russia

19 MAIDEN NAME OF MOTHER Rebecca Lomd

20 BIRTHPLACE OF MOTHER (City) - (State or country) Russia

21 Informant Anne Siegal

(Address) 49 Boylston St. Malden, Mass.

A TRUE COPY ATTEST: Marian J. Schneiderman
(Registrar of City or Town where death occurred)

DATE FILED 10/2/67 19....

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

OCT 4 '67 AM

VM

M R-305

— USE ONLY APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

209

Danvers (City or town making return)

Registered No. .....

PLACE OF DEATH

1 Essex (County)

Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mabel Carty (Ricker) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 79 Summit Avenue St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 5 months 18 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute cardio-respiratory failure due to coronary sclerosis-following vertebral fx

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury March 7 19 67

If accidental, was injury causally related to the death? No

Where did Injury occur? Winthrop, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home (Specify type of place)

Manner of Injury Fell on floor (How did injury occur?)

Nature of Injury Fx lumbar vertebra

While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Dougald C. MacGillivray M. D.

(Address) 10 Berry St., Danvers Date 19 10/2/67

7 Winthrop Cemetery Winthrop
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL October 4 19 67

8 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed OCT 18 1967 19....

John O'Neil
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female

10 COLOR white

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of unknown
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 90 Years 1 Months 4 Days — If under 24 hours ....Hours ....Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. 012-10-8570-D

17 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

18 NAME OF FATHER Ansel Ricker

19 BIRTHPLACE OF FATHER (City) Somersworth (State or country) New Hampshire

20 MAIDEN NAME OF MOTHER unknown

21 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

22 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY.
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED October 6 19 67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

OCT 18 67 AM

TOWN CLERK
MASS.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

210

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 37 Court Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marion A. Dealy (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 37 Court Road St. Winthrop (City or town and State)

Length of stay: In place of death 63 years – months – days. In place of residence 63 years – months – days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 4, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1963 to Oct 4, 1967

I last saw he alive on Oct 3, 1967, death is said to have occurred on the date stated above, at 7.13 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Thrombosis	12 hrs.
Due To (b) Angina Pectoris	4 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS none	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles J. Ferrera, M. D.

Charles J. Ferrera MD (Print or Type Name)

(Address) Winthrop Mass. Date 10-5- 1967

6 Winthrop (Place of Burial or Cremation) Winthrop Mass. (City or Town)

DATE OF BURIAL Oct. 7, 1967

7 NAME OF FUNERAL DIRECTOR Harvey P. Morrison

ADDRESS 13 Yale Ave. Wakefield Mass.

Received and filed OCT 6 1967 19..... (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 63 Years 1 Months 28 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation School teacher (Kind of work done during most of working life)

14 Industry or Business: Public school

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop (State or country) Mass.

PARENTS

17 NAME OF FATHER William F. Dealy

18 BIRTHPLACE OF FATHER (City) East Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Ellen M. Moriarty

20 BIRTHPLACE OF MOTHER (City) South Boston (State or country) Mass.

21 Informant Paul B. Dealy

(Address) 65 Perkins St. Stoneham Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G Vitaghano (Signature of Agent of Board of Health or other)

Dir of Public Health (Official Designation) 10/5/67 (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 6 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 211

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town); WINTHROP COMMUNITY HOSPITAL No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: ANNA G (WHITE) WADLAND
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 30 BOWDOIN STREET St. WINTHROP (City or town and State)

Length of stay: In place of death ..... years 1 months 22 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: OCTOBER 4, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 1, 1963, to Oct 4, 1967
I last saw he alive on 10/4/67, death is said to have occurred on the date stated above, at 3:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cancer Rt. BREAST — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical Operative.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Chas. O. Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 10/14/1967

6 Place of Burial or Cremation: Winthrop (City or Town): Winthrop
DATE OF BURIAL: Oct 7 1967

7 NAME OF FUNERAL DIRECTOR: Ernest T Caggiano
ADDRESS: 147 Winthrop St Winthrop

Received and filed: OCT 6 1967 19..... John A Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of GEORGE J WADLAND (Husband's name in full)

12 AGE 63 Years 8 Months 15 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at Home

15 Social Security No. 024-28-8480

16 BIRTHPLACE (City) Chelsea (State or country) Mass

PARENTS
17 NAME OF FATHER: John J White
18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland
19 MAIDEN NAME OF MOTHER: Catherine Hennessey
20 BIRTHPLACE OF MOTHER (City) Chelsea (State or country) Mass.

21 Informant: George W Wadland
(Address) 15 James Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip A. Vitagliano (mex)
(Signature of Agent of Board of Health or other)
Director of Public Health 10-6-67
(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 212

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. 636 Pleasant St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Katherine Ciampa. (Bianco)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 636 Pleasant St. St. (City or town and State)

Length of stay: In place of death 17 years ..... months ..... days. In place of residence 17 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct (Month) 5 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb, 1967, to Oct 5, 1967
I last saw her alive on Oct. 1, 1967, death is said to have occurred on the date stated above, at 6:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Multiple Sclerosis	20 yrs.
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Bil. Basal Pneumonia	8 mos.

Was autopsy performed? No.
What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) D. D. Potito, M. D.
D D POTITO MD.
(Print or Type Name)
(Address) 17A Bennington St E. B. Date 10/5 1967

6 Holy Cross. Malden, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 7 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.
ADDRESS 917 Bennington St. E. Boston

Received and filed OCT 6 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Joseph A. Ciampa (Husband's name in full)

12 AGE 52 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housework (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. C. B. L.

16 BIRTHPLACE (City) East Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Nicholas Bianco

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Catherine McMahon

20 BIRTHPLACE OF MOTHER (City) Salem (State or country) Mass.

21 Informant Mr. Joseph A. Ciampa-hus.
(Address) 636 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir of Public Health 10/5/67
(Official Designation) (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 6 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 213

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. BayView Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Emilia Haggstrom (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 72 Eustis St. Cambridge (City or town and State)

Length of stay: In place of death ..... years 14 months ..... days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 9 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug, 1966, to Oct 9, 1967

I last saw her alive on Oct 9, 1967, death is said to have occurred on the date stated above, at 2:33 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary occlusion	minutes
Due To (b) myocardial heart disease	yr
Due To (c)	
OTHER SIGNIFICANT CONDITIONS arteriosclerosis Gen	yr

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie, M. D.

Joseph GREGORIE (Print or Type Name)

(Address) 194 Washington Ave Date 10/9/1967

6 Mt. Hope Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 12 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed OCT 11 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Otto H. HAGGSTROM (Husband's name in full)

12 AGE 84 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. CNBL

16 BIRTHPLACE (City) (State or country) Finland

PARENTS

17 NAME OF FATHER Carl Fagerholm

18 BIRTHPLACE OF FATHER (City) (State or country) Finland

19 MAIDEN NAME OF MOTHER Clara Joanna - - -

20 BIRTHPLACE OF MOTHER (City) (State or country) Finland

21 Informant Helen Indingaro

(Address) 221 Paris St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Div of Public Health 10/11/67
(Official Designation) (Date of Issue of Permit)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Cambridge notified 11-7-67

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 214

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anna Blangio (DeCristoforo) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 144 St. Andrew Rd. East Boston, Mass. St. (City or town and State)

Length of stay: In place of death ..... years ..... months 20 days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 13 (Month) 1967 (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1967, to 10/13, 1967. I last saw her alive on 10/12, 1967, death is said to have occurred on the date stated above, at 5:20 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypertensive Heart	
Due To (b) Des. with L. Bundle	
Due To (c) Branch Block	3 weeks
OTHER SIGNIFICANT CONDITIONS Hypertension, Arterial Occlusion of Both leg c̄ gangrene	5 yrs, 7 days

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) D. D. Potito, M. D.
D D POTITO MD
(Print or Type Name)
(Address) 12A Bennington St Date 10/13 1967

6 St. Michaels Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 16th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed OCT 13 1967 19

John B Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Female	White	Widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Albert R. Blangio (Husband's name in full)

12 AGE 75 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. No

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Charles DeCristoforo

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Italy

19 MAIDEN NAME OF MOTHER Concetta Santsuosso

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Italy

21 Informant Mr. Albert J. Blangio-son
(Address) 101 Bartlett St., Somerville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (D)
(Signature of Agent of Board of Health or other)

Director of Public Health 10/13/67
(Official Designation) (Date of Issue of Permit)

DOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 13 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP MASS.

E.B. NOTIFIED 11-7-67

MR-301A

TRUCTIONS FOR L CERTIFICATE

1 giving S OF DEATH

not enter : than one e for each (b) and (c)

h does not mean rte of dying, heart failure, etc. It means ise, or compli- s which caused

dons, if any, chgave rise to e cause (a), in the under- g cause last.

ons contrib- t death but not the terminal ondition given

e. Chapter 137, of 954, requires ics to print or cause or f death on ctificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
To be filed for burial permit with Board of Health or its Agent.

Registered No. 215

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)
No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas H. McGinnis
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Residence. No. 51 Manning Rd. St. Lynn
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 7 months days. In place of residence 70 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1967, to Oct. 15, 1967
I last saw him alive on Oct. 15, 1967, death is said to have occurred on the date stated above, at 8:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs
Due To (b) Arteriosclerosis generalized — yrs
Due To (c) —
OTHER SIGNIFICANT CONDITIONS Cirrhosis of liver & ascites — Months

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregorie, M. D.
(Address) 194 Washington St. Date Oct. 15 1967

6 Place of Burial or Cremation Pine Grove Cem. (City or Town) Lynn
DATE OF BURIAL Oct. 16 1967

7 NAME OF FUNERAL DIRECTOR W. C. Parker
ADDRESS Lynn Mass.

Received and filed OCT 17 1967 19
John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Emma RAYMOND (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Tacker (Kind of work done during most of working life)

14 Industry or Business: Leather

15 Social Security No. 034-03-1223

16 BIRTHPLACE (City) Peabody (State or country) Mass.

PARENTS
17 NAME OF FATHER John McGinnis
18 BIRTHPLACE OF FATHER (City) (State or country) Ireland
19 MAIDEN NAME OF MOTHER Theresa Ready
20 BIRTHPLACE OF MOTHER (City) (State or country) Prince Edw. Island

21 Informant Anna Bova
(Address) Lynn Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglisano (P.)
(Signature of Agent of Board of Health or other)
Director of Public Health 10/17/67
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

A TRUE COPY ATTEST:

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION ..... NOV 17 '67 PM

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

OFFICE OF THE TOWN CLERK
WINTHROP MASS.

Lynn notified 11-7-67

FORM R-301

led for burial permit
Board of Health
or its Agent.

NSTRUCTIONS
FOR
CAL CERTIFICATE

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cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

Medical examiner notified — referred to board of health.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 216

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 112 BROOKFIELD RD. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARGARET E REDDY (WILKINSON.)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 112 BROOKFIELD RD St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 15, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 9:15 P.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Death presumably due to
Due To (b) natural causes, probably
Due To (c) hypertensive arteriosclerotic heart disease on basis of history
OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Lieberman M.D.

Was autopsy performed? No
What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Charles Lieberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 10/15/19 67

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL OCT 19 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP MASS.

Received and filed OCT 17 1967 19....
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of JAMES F REDDY
(Husband's name in full)

12 AGE 63 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. 017-22-1502

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER JAMES H WILKINSON

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY H. DERMODY

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS.

21 Informant JAMES T REDDY
(Address) 37 PLEASANT PK RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 10/17/67
(Official Designation) (Date of Issue of Permit)

53-936348

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 17 '67 PM

OFFICE OF TOWN CLERK
WINCHESTER, MASS

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 217

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sutherland Mae C. (BLACKBURN)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 71 Grovers Ave. Winthrop St (City or town and State)

Length of stay: In place of death ....years ....months 15 days. In place of residence 7 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 17 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1967, to Oct 17, 1967
I last saw her alive on Oct. 16, 1967, death is said to have occurred on the date stated above, at 6:15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease — INTERVAL BETWEEN ONSET AND DEATH: yrs
Due To (b) arteriosclerosis gen. — yrs
Due To (c) ....
OTHER SIGNIFICANT CONDITIONS Cerebrovascular accident left hemiplegia — 16 da

Was autopsy performed? ....
What test confirmed diagnosis? ....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ....

(Signature) Joseph Gregorie, M. D.
(Print or Type Name) JOSEPH GREGORIE
(Address) 194 Washington St Winthrop Date 10-17 1967

6 Place of Burial or Cremation: Winthrop Cemetery (City or Town) Winthrop
DATE OF BURIAL October 19, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed OCT 18 1967 19....
John O Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): WIDOW

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Alexander Sutherland
(Husband's name in full)

12 AGE 83 Years ....Months ....Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. ....

16 BIRTHPLACE (City) Gloucester (State or country) Mass

PARENTS

17 NAME OF FATHER William Blackburn

18 BIRTHPLACE OF FATHER (City) Lancashire (State or country) England

19 MAIDEN NAME OF MOTHER Elizabeth Hunt

20 BIRTHPLACE OF MOTHER (City) Lancashire (State or country) England

21 Informant Paul T. Barry
(Address) 71 Grovers Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me, BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)
Director of Public Health 10/18/67
(Official Designation) (Date of Issue of Permit)

.00M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

o be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 218

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

JOHN C. VITAGLIANO

2 FULL NAME John Vitagliano
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

201 Cottage Park Road

(a) Permanent Residence. No. 201 Cottage Pk. Rd St. Winthrop (City or town and State)

Length of stay: In place of death 7 years ..... months ..... days. In place of residence 41 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 18 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct., 1966, to October 18, 1967

I last saw him alive on Oct. 16, 1967, death is said to have occurred on the date stated above, at 4:44 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yrs
Due To (b) arteriosclerosis gen	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph Gregorie, M. D.
JOSEPH GREGORIE
(Print or Type Name)

(Address) 194 Washington Ave Winthrop Date Oct. 18 1967

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 21, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed OCT 20 1967 19

John A Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
male	white	widowed

11 If married, widowed, or divorced HUSBAND of Michela Sarno
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 83 Years 4 Months 7 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired Grocer
(Kind of work done during most of working life)

14 Industry or Business: Self-employed

15 Social Security No. 011-26-9077

16 BIRTHPLACE (City) Avellino
(State or country) Italy

PARENTS

17 NAME OF FATHER Carmen Vitagliano

18 BIRTHPLACE OF FATHER (City)
(State or country) Italy

19 MAIDEN NAME OF MOTHER Information Unavailable

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

21 Informant Mrs. Dorothy Princi
(Address) 46 Bartlett Parkway, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)

Director of Public Health 10/20/67
(Official Designation) (Date of Issue of Permit)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 20 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 219

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME LOUISE (RAUSCH) LUTZE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Permanent Residence. No. 110 CIRCUIT ROAD St. WINTHROP
(City or town and State)

Length of stay: In place of death ....years....months 13 days. In place of residence 37 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1962, to Oct. 19, 1967
I last saw he alive on Oct. 19, 1967, death is said to have occurred on the date stated above, at 12:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

Due To (b) Heart Disease

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS Anemia, Pericolic Abscess — 2 months

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 10/19/1967

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 23 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed OCT 20 1967 19....
John L Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Frederick C Lutze
(Husband's name in full)

12 AGE 83 Years 0 Months 15 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. 022-03-3217

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Christian Rausch

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Germany

19 MAIDEN NAME OF MOTHER Amelia Rudolph

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Germany

21 Informant Frederick C Lutze
(Address) 110 Circuit Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health 10/20/67
(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 20 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

RM R-303

filed for burial permit
h Board of Health
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93634B

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 220

1 PLACE OF DEATH
SUFFOLK (County)
Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME LETITIA (First Name) C. (Middle Name) HYDE (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 647 Saratoga St. East Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....7....days. In place of residence....50....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 21, (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease.
Acute pulmonary edema.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print Name)
(Address) Boston, Mass. Date 10/22 19 67

7 Holy Cross Place of Burial or Cremation. Malden (City or Town)
DATE OF BURIAL Oct. 25 1967

8 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH
ADDRESS East Boston

Received and filed OCT 24 1967 19.....
John A. Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female
10 COLOR White
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of DANIEL HYDE
(Husband's name in full)

13 AGE 86 Years.....Months.....Days
If under 24 hours .....Hours .....Minutes

14 Usual Occupation: HOUSEWORK
(Kind of work done during most of working life)

15 Industry or Business: Own Home

16 Social Security No. CNBL

17 BIRTHPLACE (City) (State or country) BOSTON MASS.

PARENTS
18 NAME OF FATHER Michael FERREIRA
19 BIRTHPLACE OF FATHER (City) (State or country) VIRGIN ISLANDS
20 MAIDEN NAME OF MOTHER MARGARET KEENAN
21 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

22 Informant MARGARET LE BLANC
(Address) 256 MAIN ST. MEDFORD

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (R)
(Signature of Agent of Board of Health or other)
Director of Public Health 10/24/67
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

E B notified 11-7-67

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 221

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Michael Dattoli (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 196 Woodside Avenue St. Winthrop (City or town and State)

Length of stay: In place of death.....years.....months....4....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: October (Month) 22 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN. 1, 1962, to Oct. 22, 1967. I last saw him alive on Oct. 22, 1967 death is said to have occurred on the date stated above, at 10:02 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion Acute — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Due To (b) Arteriosclerotic Heart — 3 yrs.

Due To (c) Disease —

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman M.D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS. Date 10/22/1967

6 Woodlawn Cemetery Everett (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL October 25 1967

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., E. Boston, Mass.

Received and filed OCT 23 1967 19....

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Mary Giggi (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 68 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Shoe Worker (Kind of work done during most of working life)

14 Industry or Business: Copley Shoe

15 Social Security No. 011-03-7991A

16 BIRTHPLACE (City) (State or country): Italy

PARENTS

17 NAME OF FATHER: Ciriaco Dattoli

18 BIRTHPLACE OF FATHER (City) (State or country): Italy

19 MAIDEN NAME OF MOTHER: Rosina Giorgia

20 BIRTHPLACE OF MOTHER (City) (State or country): Italy

21 Informant: Mary Dattoli (wife)

(Address) 196 Woodside Ave., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 10/23/67 (Date of Issue of Permit)

100M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 23 '67 PM

OFFICE OF THE TOWN CL
WINTHROP, MASS.

M R-305

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Danvers
(City or town making return)

Registered No. 222

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emily Silviera
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 33 Forest St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 1 months 2 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 22, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Bronchopneumonia following operation for right hip fracture.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury September 25 19 67
If accidental, was injury causally related to the death? Yes
Where did Injury occur? Hathorne, Mass.
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? State Hospital
(Specify type of place)
Manner of Injury Fell on floor
(How did injury occur?)
Nature of Injury Rt. hip fracture
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased No
If so, specify
(Signed) Dougald C. MacGillivray, M. D.
(Address) 10 Berry St., Danvers Date 10/22/67

7 Calvary Cemetery Woburn
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL October 25 19 67

8 NAME OF FUNERAL DIRECTOR Rogers Funeral Home
ADDRESS Cambridge, Mass.

Received and filed OCT 30 1967 19....
John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: female
10 COLOR: white
11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Sliviera
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 87 Years 8 Months 9 Days
If under 24 hours ....Hours ....Minutes

14 Usual Occupation: at home
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 016-40-9608-T

17 BIRTHPLACE (City) St. George
(State or country) Azores

PARENTS

18 NAME OF FATHER Joseph Sears

19 BIRTHPLACE OF FATHER (City)
(State or country) Azores

20 MAIDEN NAME OF MOTHER Mary Sears

21 BIRTHPLACE OF MOTHER (City)
(State or country) Azores

22 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY.
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED October 26 19 67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

OCT 30 '67 AM

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass.
(City or Town making this return)

Registered No. 223

1 PLACE OF DEATH
Suffolk (County)
Winthrop, Mass. (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Adamson Henry A. Farquhar, Jr.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W.2

(a) Permanent Residence. No. 28 South Main St. St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death ....years....months.1....days. In place of residence 28 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 22, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1950, to Oct 22, 1967, I last saw him alive on Oct 22, 1967, death is said to have occurred on the date stated above, at 4:02 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	ACUTE ANTERO-SEPTAL MYOCARDIAL INFARCTION	8 HRS
Due To (b)	RT. BUNDLE BRANCH BLOCK + VENTRICULAR PROMATURE BEATS	8 HRS.
Due To (c)	ARTERIO-SCLEROTIC HEART DIS	8 HRS.
OTHER SIGNIFICANT CONDITIONS	NONE	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & EKG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
Myron N. King MD
(Print or Type Name)
(Address) 22 Pleasant St. Winthrop Mass. Date Oct 24 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL October 25, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop

Received and filed OCT 25 1967
John A Clear (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE
9 COLOR WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced
HUSBAND of Alice Grant
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 51 Years 9 Months 11 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business: Lynn General Electric Co.

15 Social Security No. 013-01-3724

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Henry Adamson Farquhar, Sr.

18 BIRTHPLACE OF FATHER (City)
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Margaret MacKerron

20 BIRTHPLACE OF MOTHER (City)
(State or country) Scotland

21 Informant Mrs. Henry A. Farquhar
(Address) 28 So. Main St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip A. Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health 10/25/67
(Official Designation) (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 2-18-44

DATE OF DISCHARGE 12-27-45

RANK, RATING ..... Machinist's Mate 3rd. Class

ORGANIZATION AND OUTFIT ..... U.S. Navy

SERVICE NUMBER 803 73 88

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MV

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 224

1 PLACE OF DEATH: Suffolk (County) — Winthrop, Mass. (City or Town) — No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Winthrop, Mass. (City or Town making this return)

2 FULL NAME: Mary Grady (McGuire)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 10 Walley St. St. East Boston, Mass. (City or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 30 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: October (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 1965, to OCT 24 1967, I last saw him/her alive on OCT 24 1967, death is said to have occurred on the date stated above, at 6.47 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIO-SCLEROTIC HEART DIS & CONGESTIVE FAILURE	6 MO
Due To (b) CHRONIC ASTHMATIC BRONCHITIS +	3 YRS
Due To (c) EMPHYSEMA	
OTHER SIGNIFICANT CONDITIONS: PERIPHERAL VASCULAR DIS	6 MO.

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & X-ray.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
Myron N. King M D
(Print or Type Name)
(Address) 22 Pleasant St. Winthrop Mass Date OCT 24 67

Place of Burial or Cremation: Woodlawn (City or Town) Everett

DATE OF BURIAL: Oct 27 1967

7 NAME OF FUNERAL DIRECTOR: Frederick J. Magrath

ADDRESS: East Boston

Received and filed OCT 26 1967 19..
John H Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of ALEXANDER GRADY
(Husband's name in full)

12 AGE 67 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: HOUSEWORK (Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. CNBL

16 BIRTHPLACE (City) (State or country): BOSTON MASS

PARENTS

17 NAME OF FATHER: JOSEPH MAGUIRE

18 BIRTHPLACE OF FATHER (City) (State or country): CORK IRELAND

19 MAIDEN NAME OF MOTHER: MARY E. CUNNINGHAM

20 BIRTHPLACE OF MOTHER (City) (State or country): ALBANY N.Y.

21 Informant: Ruth Lino
(Address) 12 Gladstone St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 10/26/67 (Date of Issue of Permit)

OOM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

E B notified 11-7-67

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 225

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RALPH SWARTZ
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 8 OAK STREET St. NATICK (City or town and State)

Length of stay: In place of death ....years ....months 10 days. In place of residence 11 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 26, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1967 to Oct. 26, 1967

I last saw him alive on Oct. 26, 1967, death is said to have occurred on the date stated above, at 11:40 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

Due To (b) cause undetermined

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cerebrovescular Occlusion with Right Hemiplegia — 6 months

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 10/26/1967

6 Tifereth Israel of Winthrop, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 29, 1967

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon st. Brookline

Received and filed OCT 27 1967

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of Mary Disfriend
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 79 Years 5 Months 11 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation Salesman
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 032-18-6641

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Mayer Swartz

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Molly Cohen

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Ellis Swartz
(Address) 45 Oval Rd., Quincy

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Director of Public Health 10/27/67
(Official Designation) (Date of Issue of Permit)

OOM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 27 '67 PM

OFFICE O... CLERK
WINT...

Natick
Notified 11-7-67

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Medical examiner notified — Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 226

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. ENROUTE TO WINTHROP COMMUNITY HOSP. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME PHILIP KRAVETZ
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 106 GROVERS AVENUE St. WINTHROP (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 23, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 9:30 AM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes, probably

Due To (c) acute coronary occlusion on basis of history

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? Charles Lieberman M.D.

What test confirmed diagnosis? N.C.

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 10/23/19 67

6 Place of Burial or Cremation TIFERETH ISRAEL OF WINTHROP, EVERETT (City or Town)

DATE OF BURIAL OCTOBER 24 19 67

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV., INC.

ADDRESS 1615 BEACON ST., BROOKLINE

Received and filed OCT 23 1967 19.....

John Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed or divorced HUSBAND of SADIE WINOKUR (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 65 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation TRUCKING CO. EXECUTIVE (Kind of work done during most of working life)

14 Industry or Business: TRANSPORTATION

15 Social Security No. 034-14-3372

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER ABRAHAM ISAAC KRAVETZ

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER CELIA PEVIN

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant ALLAN H. KRAVETZ (SON)

(Address) 2 TEMPLE RD., LYNNFIELD

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 10/23/67 (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 23 '67 PM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or complications which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not lated to the terminal sease condition given (a).

Funeral Director: Please use only BLACK ink.

M-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT OF TOWN

227

Boston (City or Town making this return)

Registered No. ~~08-51~~

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hilda W. Findlay (Johnson) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. ~~66 Shore Drive~~ Apt. C 4 Viking Gardens St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 5 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 21, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 16, 1967, to August 21, 1967. I last saw her alive on August 21, 1967, death is said to have occurred on the date stated above, at 2:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

Due To (b) Aortic Stenosis — Unknown Years

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Aug. 21, 1967

6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop Street, Winthrop

Received and filed AUG 29 1967

William J. Kane (Registrar)

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) divorced

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of David Findlay (Husband's name in full)

12 AGE 85 Years 9 Months 29 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired laundress (Kind of work done during most of working life)

14 Industry or Business: Baptist Hospital

15 Social Security No. 028-12-4736

16 BIRTHPLACE (City) (State or country) Sweden

PARENTS

17 NAME OF FATHER Carl Johnson

18 BIRTHPLACE OF FATHER (City) (State or country) Sweden

19 MAIDEN NAME OF MOTHER Clara Sofia Johnson

20 BIRTHPLACE OF MOTHER (City) (State or country) Sweden

21 Informant Mrs. Thomas V. McClintock

(Address) Apt. C 4 Viking Gardens Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Eugene Leonard E 127.52 (Signature of Agent of Board of Health or other)

(Official Designation) August 23 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

Registered & Voted from 19 Moore St., Winthrop

DEC 6 '87 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

OUT OF TOWN

228

FORM R-301

o be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

BOSTON (City or Town making this return)

Registered No. 8040

1 PLACE OF DEATH: SUFFOLK (County)

BOSTON (City or Town)

No. BETH ISRAEL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME HYMAN FISHMAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 380 SHIRLEY St. WINTHROP MASS (City or town and State)

Length of stay: In place of death ....years....months 15 days. In place of residence 12 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUG (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 8/15, 1967, to 8/30, 1967

I last saw him alive on 8/30/67, 1967, death is said to have occurred on the date stated above, at 10:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Heart failure.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Richard K. Straley, M. D.
RICHARD K. STRALEY (Print or Type Name)

(Address) BETH ISRAEL HOSP. Date 8/30 1967

6 Place of Burial or Cremation: Beth Israel of Camb. Everett (City or Town)

DATE OF BURIAL Sept. 1, 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed SEP 6 1967

William J. Bane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Divorced

11 If married, widowed or divorced HUSBAND of Edith Barrett (Give maiden name of wife in full)

(or) WIFE of ....(Husband's name in full)

12 AGE 69 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: Dentist (Kind of work done during most of working life)

14 Industry or Business: Dentistry

15 Social Security No. c/n/b/l/

16 BIRTHPLACE (City) c/n/b/l/ (State or country) Rumania

PARENTS

17 NAME OF FATHER Solomon Fishman

18 BIRTHPLACE OF FATHER (City) c/n/b/l/ (State or country) Rumania

19 MAIDEN NAME OF MOTHER Faige Barnett

20 BIRTHPLACE OF MOTHER (City) c/n/b/l/ (State or country) Rumania

21 Informant: Mrs. Edith Fishman
(Address) 380 Shirley St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Carl Carl E 13 0 2 (Signature of Agent of Board of Health or other)

Sept 1 - 1967 (Official Designation) (Date of Issue of Permit)

420.1
81
X20

OM-8-66-943275

A TRUE COPY ATTEST:

William J. Kane.

OUT OF TOWN

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

BOSTON 229
(City or Town making this return)

Registered No. 1967-116

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FRED WOOD S.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Permanent Residence. No. Plymouth Mobile Park xx Plymouth, Mass.
(City or town and State)

Length of stay: In place of death ..years 1 months 4 days. In place of residence ..years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 7 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 4, 1967, to September 7, 1967, death is said to have occurred on the date stated above, at 5:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute myocardial infarction	days
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Carcinoma of lung Necrotizing pancreatitis	1 yr wks.

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify No

(Signature) K. Azmudeh, M. D.
Kembiz Azmuden
(Print or Type Name)
(Address) VAH, Boston, Mass. Date Sept. 8, 1967

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 11, 1967

7 NAME OF FUNERAL DIRECTOR R. C. Kirby Funeral Home
ADDRESS 917 Bennington St., E. Boston, Mass.

Received and filed SEP 12 1967, 19..
Elizabeth J. Davis (Registrar)
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
Male	White	Married

11 If married, widowed, or divorced
HUSBAND of Mary Picard
(Give maiden name of wife in full)
(or) WIFE of ..
(Husband's name in full)

12 AGE 79 Years 3 Months 20 Days | If under 24 hours ..Hours ..Minutes

13 Usual Occupation Ferry Operator
(Kind of work done during most of working life)

14 Industry or Business: City of Boston

15 Social Security No. 025-363-310-T

16 BIRTHPLACE (City) Newton (State or country) Mass.

PARENTS

17 NAME OF FATHER Joseph Wood

18 BIRTHPLACE OF FATHER (City) .. (State or country) Quebec

19 MAIDEN NAME OF MOTHER Virginba Delorey

20 BIRTHPLACE OF MOTHER (City) .. (State or country) Nova Scotia

21 Informant VA Hospital Records, 150 So. Huntington Ave., Boston, Mass.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
E13373 (Official Designation) Sept. 9, 1967 (Date of Issue of Permit)

120.1
8/20

DOM-8-66-943275

William J. Kane.
City Registrar

OCT 5 '67 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

D-3

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

IDOM-9-63-936348

2-6

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

BOSTON (City or Town making this return) 230

Registered No. 08753

No. En route to Massachusetts General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME FRANCIS (First Name) MELVILLE (Middle Name) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) W.W.I

(a) Permanent Residence. No. 332 Bunker Hill Street, Charlestown St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 11 (Day), 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute myocardial infarction.

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury ..... 19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 9/11 1967

7 Winthrop Cem. Winthrop (City or Town)
Place of Burial or Cremation.
DATE OF BURIAL Sept. 15 1967

8 NAME OF FUNERAL DIRECTOR John H. Sawyer
ADDRESS 329 Bunker Hill St. Chas'n.
Received and filed SEP 15 1967 19.....
A TRUE COPY ATTEST: William J. Crane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male
10 COLOR: White
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

12 If married, widowed, or divorced HUSBAND of Irene McCarthy (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 AGE 70 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired Dispatcher (Kind of work done during most of working life)

15 Industry or Business: Boston Naval Shipyard

16 Social Security No. 021-01-5635

17 BIRTHPLACE (City) (State or country) Charlestown Mass.

PARENTS

18 NAME OF FATHER Thomas Melville

19 BIRTHPLACE OF FATHER (City) (State or country) UNKNOWN

20 MAIDEN NAME OF MOTHER Susan Howe

21 BIRTHPLACE OF MOTHER (City) (State or country) Canada

22 Informant (Address) Irene Melville
332 Bunker Hill St. Charlestown

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[signature]
(Signature of Agent of Board of Health or other)
E13516 (Official Designation) 9/13/67 (Date of Issue of Permit)

MEDICAL

ATTEST:

DEC 6 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

OUT - OF - TOWN

FORM R-301

To be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Chelsea (City or Town making this return) 231

Registered No. 499

1 PLACE OF DEATH: SUFFOLK (County) CHELSEA (City or Town)

No. CHELSEA MEMORIAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH CYBULSKY (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W.W.1

(a) Permanent Residence. No. 170 CLIFF AVE., St. WINTHROP, MASS. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER (Month) 14, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1967, to Oct 14, 1967

I last saw him alive on Oct 14, 1967, death is said to have occurred on the date stated above, at 6 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE Myocardial Infarct	36 hours
Due To (b) arteriosclerosis	15 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Pulmonary Emphysema	4 yrs

Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) William P. Finnegan, M. D.

WILLIAM P. FINNEGAN MD (Print or Type Name)

(Address) 647 BROADWAY Date Oct 15 1967

CHELSEA MASS

Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 17, 1967

7 NAME OF FUNERAL DIRECTOR J. F. McGlinchey Funeral Home Inc.

By Richard F. Norton

ADDRESS 583 Broadway, Chelsea,

Received and filed Oct 17, 1967

John P. Dalis (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Divorced

11 If married, widowed, or divorced HUSBAND of Loretta Evanchesky (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 75 Years.....Months.....Days If under 24 hours .....Hours.....Minutes

13 Usual Occupation Machinest (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 034-05-7379

16 BIRTHPLACE (City) (State or country) Poland

PARENTS

17 NAME OF FATHER Martin Cybulsky

18 BIRTHPLACE OF FATHER (City) (State or country) Poland

19 MAIDEN NAME OF MOTHER Cecelia ?

20 BIRTHPLACE OF MOTHER (City) (State or country) Poland

21 Informant Mrs. Patricia A. Angelo

(Address) 1381 Main St. Reading

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Donald F. Bedington (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 10-16-67 (Date of Issue of Permit)

100M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 9-20-17

DATE OF DISCHARGE 5-9-14

RANK, RATING ..... Pvt.

ORGANIZATION AND OUTFIT ..... U.S.G.

SERVICE NUMBER ..... 165666 T

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) Attending physicians will certify to such deaths only as those of persons to [illegible] they have given bedside care during a last illness from disease un- [illegible] any form of injury.

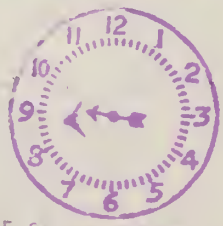
(2) Board of Health physicians will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 30 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

A TRUE COPY ATTEST:

City Clerk

MX

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

232

Revere (City or Town making this return)

Registered No. .....

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town)

No. Oceanview Manor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Samuel Kaufman (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 37 Tewksbury St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 15, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan., 1950, to Oct. 15, 1967

I last saw h.....alive on Oct. 15, 1967, death is said to have occurred on the date stated above, at 11:15 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypertensive Arterio-sclerotic Heart Disease	10 yrs
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signature) Charles Liberman, M. D.

(Address) Winthrop, Mass. Date 10/15/67

6 Montifore Society, Woburn (City or Town)
Place of Burial or Cremation

DATE OF BURIAL October 16, 1967

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service, Inc.

ADDRESS 151 Washington Ave., Chelsea

Received and filed NOV 20 1967 19....

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Mae Millen (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 86 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Plumber (Kind of work done during most of working life)

14 Industry or Business: Boston Elevated Street Rwy.

15 Social Security No. 024-10-2019

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Abraham Kaufman

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Bessie (C.B.L.)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant William E. Kaufman

(Address) 37 Tewksbury St., Winthrop

A TRUE COPY

ATTEST: Joseph F. McShield
(Registrar of City or Town where death occurred)

DATE FILED October 16, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

NOV 20 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

233

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: Middlesex (County) — Cambridge (City or Town) — Cambridge (City or Town making this return)

Registered No. 1497

No. Holy Ghost Hospital, Cambridge St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Amelia Baxter (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 97 Grovers Avenue St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years 8 months 9 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: October 16, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1967, to October 16, 1967

I last saw her alive on October 16 1967 death is said to have occurred on the date stated above, at 8:15 pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gram Negative Septicemia

Due To (b) due to Chronic and Acute Pyelonephritis

Due To (c) Subarachnoid Hemorrhage from

OTHER SIGNIFICANT CONDITIONS: Aneurysm with Rupture into Both Frontal Lobes

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) John F. Lee, M. D.

Holy Ghost Hospital

(Address) Cambridge, Mass. Date Oct. 17 1967

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 19 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed NOV 17 1967 S 19

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Ernest W. Baxter (Husband's name in full)

12 AGE 55 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Beautician (Kind of work done during most of working life)

14 Industry or Business: Hair Dressing

15 Social Security No.

16 BIRTHPLACE (City) (State or country): Worcester Mass.

PARENTS

17 NAME OF FATHER: Peter Carbone

18 BIRTHPLACE OF FATHER (City) (State or country): Italy

19 MAIDEN NAME OF MOTHER: Cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country): Italy

21 Informant Ernest W. Baxter

(Address) 97 Grovers Ave., Winthrop

A TRUE COPY

ATTEST: Thomas M McNamara
(Registrar of City or Town where death occurred)

DATE FILED Oct. 18, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

NOV 17 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

234

Danvers
(City or Town making this return)

Registered No. . . .

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Cushing
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 26 Center Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ....years 2 months 24 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 25, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1967 to October 25, 1967
I last saw him alive on October 25, 1967 Death is said to have occurred on the date stated above, at 9:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cardio-respiratory failure hrs.
Due To (b) Arteriosclerotic heart disease yrs.
Due To (c) Generalized arteriosclerosis yrs.
OTHER SIGNIFICANT CONDITIONS Cystitis

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No
What test confirmed diagnosis Clinical&Laboratory

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Willard M. Hausman, M. D.
(Address) Hathorne, Mass. Date 10/26/67

6 Place of Burial or Cremation Holy Cross Cemetery (City or Town) Malden
DATE OF BURIAL October 30, 1967

7 NAME OF FUNERAL DIRECTOR O"Malley Funeral Home
ADDRESS Winthrop, Mass.

Received and filed NOV 14 1967
John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male
9 COLOR white
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) widowed

11 If married, widowed, or divorced
HUSBAND of Mary Brennan
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 81 Years 5 Months 21 Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: ....

15 Social Security No. 017-10-0878

16 BIRTHPLACE (City) (State or country) Newton Mass.

PARENTS
17 NAME OF FATHER Gardner Cushing
18 BIRTHPLACE OF FATHER (City) (State or country) Ireland
19 MAIDEN NAME OF MOTHER Catherine Fennish
20 BIRTHPLACE OF MOTHER (City) (State or country) P.E.I.

21 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)
DATE FILED October 30, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

Veteran's residence
170 Cliff Ave, Winthrop

JAN 14 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

7L

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 235

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MORRIS GLASS (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 20 MYRTLE AVENUE WINTHROP MASSACHUSETTS (City or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 3 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1967, to NOV. 3, 1967

I last saw him alive on Nov. 3, 1967, death is said to have occurred on the date stated above, at 7:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute Coronary Occlusion	3 wks.
Due To (b)	Arteriosclerotic Heart	5 yrs
Due To (c)	Disease.	
OTHER SIGNIFICANT CONDITIONS	NONE	

Was autopsy performed? No

What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date Nov. 3 1967

6 Jewish Deed Holders Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 5 1967

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home Inc

ADDRESS 420 Harvard St Brookline

Received and filed NOV 6 1967 19

John B Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Anna Weiseman (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 69 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired (Kind of work done during most of working life)

14 Industry or Business: Dry Goods Store

15 Social Security No. 010-28-1385

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Herchel Glass

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Bessie Unknown

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Anna Glass (Wife)

(Address) 20 Myrtle Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 11/5/67
(Official Designation) (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV - 6 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP MASS.

FORM R-301

...ed for burial permit
... Board of Health
...r its Agent.

...ISTRUCTIONS FOR ...AL CERTIFICATE

...NT OR TYPE ...E OR CAUSES ...F DEATH

...o not enter ...re than one ...use for each ...), (b) and (c)

...l does not meon ...ode of dying, ...s heart failure, ...ea, etc. It meons ...ease, or compli... which coused

...itions, if any, ...h gave rise to ...e cause (a), ...ng the under... cause last.

...nditions contrib... ...o death but not ...e to the terminal ...condition given ...o

Medical Examiner Notified - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 236

1 PLACE OF DEATH: Suffolk (County) Winthrop (City or Town)

No. 132 LOCUST WAY St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James F. McLaughlin (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 132 Locust Way St. Winthrop (Usual place of abode) (City or town and State)

Length of stay: In place of death 50 years ... months ... days. In place of residence 50 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 6, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h...alive on ..., 19..., death is said to have occurred on the date stated above, at 3:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes, probable an

Due To (c) acute coronary occlusion on basis of history

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman MD

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS. Date 11/7/1967

6 Winthrop Cem Winthrop (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Nov 9, 1967 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St. WINTHROP

Received and filed NOV 8 1967 19...

John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male | 9 COLOR white | 10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) married

11 If married, widowed, or divorced HUSBAND of CATHERINE E O'GARA (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

12 AGE 83 Years - Months - Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation STEAM FITTER (Kind of work done during most of working life)

14 Industry or Business GENERAL

15 Social Security No. 032-03-3295

16 BIRTHPLACE (City) NEWTON LOWER FALLS (State or country) MASS

PARENTS

17 NAME OF FATHER JOHN McLAUGHLIN

18 BIRTHPLACE OF FATHER (City) ... (State or country) IRELAND

19 MAIDEN NAME OF MOTHER BRIDGET CAIN

20 BIRTHPLACE OF MOTHER (City) ... (State or country) IRELAND

21 Informant CATHERINE E McLAUGHLIN

(Address) 132 LOCUST ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr. (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) Nov. 8, 1967 (Date of Issue of Permit)

A TRUE COPY ATTEST:

-62-934553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

I be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 237

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Arthur F Bowes (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 26 Sturgis St. (City or town and State)

Length of stay: In place of death ..... years 2 months 11 days. In place of residence 55 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. (Month) 7 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 1952, to NOV 7, 1967

I last saw him alive on NOV 7, 1967, death is said to have occurred on the date stated above, at 7:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic Heart Disease	5 yrs
Due To (b)	
Due To (c) Generalized Arteriosclerosis	15 yrs
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN (Print or Type Name)

(Address) WINTHROP, MASS Date 11/7/1967

6 Mt Hope (Place of Burial or Cremation) Boston (City or Town)

DATE OF BURIAL Nov. 10 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed NOV 9 1967 19

John A Clair (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of Laura A Osborne (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 100 Years 5 Months 9 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Engineer (Kind of work done during most of working life)

14 Industry or Business: City of Boston

15 Social Security No. None

16 BIRTHPLACE (City) Halifax (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER George Bowes

18 BIRTHPLACE OF FATHER (City) Halifax (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Elizabeth Turner

20 BIRTHPLACE OF MOTHER (City) Halifax (State or country) Nova Scotia

21 Informant Francis Bowes

(Address) 1 Stonehill Drive Stoneham, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr. (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) Nov 9/67 (Date of Issue of Permit)

.00M-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV - 9 '67 AM

OFFICE

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 238

1 PLACE OF DEATH: SUFFOLK (County)
WINTHROP (City or Town)
No. BAY VIEW NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME MARGARET Mc MURRAY
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 80 INGLESIDE AVE St. WINTHROP
(City or town and State)

Length of stay: In place of death 3 years.....months.....days. In place of residence 42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 7 (Month) 1967 (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from NOV, 1940, to NOV 7, 1967
I last saw h. alive on NOV. 7, 1967 death is said to have occurred on the date stated above, at 8 PM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) VIRUS PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 12 DAYS

Due To (b)

Due To (c) SENILETY

OTHER SIGNIFICANT CONDITIONS

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (a).

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Louis F Salerno, M. D.
LOUIS F. SALERNO
(Print or Type Name)
(Address) 175 PLEASANT ST Date NOV 7 1967

6 WINTHROP — WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL NOV 11 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP, MASS

Received and filed NOV 8 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 87 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation BOOKEEPER
(Kind of work done during most of working life)

14 Industry or Business: AUTOMOBILE SALES

15 Social Security No. 023-09-5596

16 BIRTHPLACE (City) SCOTLAND
(State or country)

PARENTS

17 NAME OF FATHER JOHN McMURRAY

18 BIRTHPLACE OF FATHER (City)
(State or country) SCOTLAND

19 MAIDEN NAME OF MOTHER JANE KELLY

20 BIRTHPLACE OF MOTHER (City)
(State or country) SCOTLAND

21 Informant MARY SWENDEMAN
(Address) 80 INGLESIDE AVE WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health Nov 8 1967
(Official Designation) (Date of Issue of Permit)

M-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 239

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 19 Enfield Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Agnes C. Corcoran (Molloy)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 19 Enfield Road St. (City or town and State)

Length of stay: In place of death 30 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 9, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 11-29, 1965, to Nov. 9, 1967

I last saw her alive on Nov. 9, 1967, death is said to have occurred on the date stated above, at 4:25 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

Due To (b) arteriosclerosis - generalized — yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph Gregorie
(Print or Type Name)

(Address) 194 Washington Ave E Winthrop Date 11-10 1967

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 13, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed NOV 13 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William F. Corcoran
(Husband's name in full)

12 AGE 80 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) South Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER Thomas F. Molloy

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary E. Phelan

20 BIRTHPLACE OF MOTHER (City) South Boston
(State or country) Mass

21 Informant Mary Corcoran
(Address) 19 Enfield Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.
(Signature of Agent of Board of Health or other)

Dir of Public Health 11/13/67
(Official Designation) (Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 13 '67 PM

OFFICE OF TOWN CLERK
WINTHROP, MASS.

1 R-305

WRITE PLAINLY WITH INKING PLACE IN NO. SPACE ... RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-92100

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Danvers
(City or town making return)

Registered No. 240

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Catherine Kelleher (O'Grady)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 58 Somerset Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 4 months 16 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute cardio-respiratory failure presumably due to arteriosclerotic ht disease &/or pulmonary embolus

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury June 13 19 67
If accidental, was injury causally related to the death? Yes
Where did Injury occur? Winthrop, Mass.
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Nursing Home
(Specify type of place)
Manner of Injury Fell out of restraining chair
(How did injury occur?)
Nature of Injury Fracture L hip
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Dougald C. MacGillivray, M. D.
(Address) 10 Berry St., Danvers Date 11-9-67 19

7 Holy Cross Cemetery Malden
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL November 11 19 67

8 NAME OF FUNERAL DIRECTOR McGrath Funeral Home
ADDRESS Malden, Mass.

Received and filed NOV 27 1967 19
John B. Clone
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female
10 COLOR white
11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Dennis J. Kelleher
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 90 Years 9 Months 23 Days
If under 24 hours ....Hours ....Minutes

14 Usual Occupation: Housework
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 023-24-6933-D

17 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

18 NAME OF FATHER William O'Grady

19 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

20 MAIDEN NAME OF MOTHER unknown

21 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

22 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY.
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED November 14 19 67

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

NOV 27 '67 AM

mx

FORM R-301

ed for burial permit
Board of Health
r its Agent.

ISTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

o not enter
re than one
se for each
), (b) and (c)

does not mean
ode of dying,
s heart failure,
, etc. It means
ease, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 241

PLACE OF DEATH
I (County) SUFFOLK
(City or Town) WINTHROP
No. 2 BURRILL TERRACE (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME EDITH M WOODS (BARKER)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 2 BURRILL TERRACE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 35 years ..... months ..... days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 10, (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from Sept 8, 1967, to Nov. 10, 1967
I last saw her alive on Nov. 8, 1967, death is said to have occurred on the date stated above, at 3.00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinomatosis
Due To
(b) Carcinoma of lung
Due To
(c)
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH
weeks
2yr

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE
(Print or Type Name)
(Address) 19 Washington Ave Date 11-13 1967

6 WINTHROP
Place of Burial or Cremation WINTHROP (City or Town)
DATE OF BURIAL NOV 13 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP, MASS.

Received and filed NOV 13 1967 19
John A Clare
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of CHARLES W WOODS
(Husband's name in full)

12 AGE 35 Years .. Months ..... Days
If under 24 hours ... Hours ..... Minutes

13 Usual Occupation RECEPTIONIST.
(Kind of work done during most of working life)

14 Industry or Business HOTEL

15 Social Security No.

16 BIRTHPLACE (City) WINTHROP
(State or country) MASS

PARENTS

17 NAME OF FATHER JAMES BARKER

18 BIRTHPLACE OF FATHER (City) ~~EVERETT~~ Winthrop
(State or country) MASS

19 MAIDEN NAME OF MOTHER HILDA HALLETT.

20 BIRTHPLACE OF MOTHER (City) ~~EVERETT~~ Chelsea
(State or country) MASS

21 Informant CHARLES W WOODS
(Address) 2 BURRILL TER WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitagliano (R)
(Signature of Agent of Board of Health or other)
Director of Public Health 11/13/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 13 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
IEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ck as heart failure, thenia, etc. It means e disease, or compli-tions which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ing to death but not lated to the terminal sease condition given (a).

M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 242

1 PLACE OF DEATH: SUFFOLK (County); Winthrop (City or Town)

No. 454 Shirley St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph R. Goldburgh
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 117 Court Road St. Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 70 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 12, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept., 1960, to Nov. 11, 1967
I last saw him alive on Nov. 11, 1967, death is said to have occurred on the date stated above, at 6:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Coronary Occlusion	10 min
Due To (b) Hypertensive Arterio-	7 yrs.
Due To (c) Sclerotic Heart Disease	
OTHER SIGNIFICANT CONDITIONS Congestive Heart Failure	3 mos.

Was autopsy performed? No
What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 11/12/ 1967

6 Mishkan Tefila, West Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 14 1967

7 NAME OF FUNERAL DIRECTOR Morris W. Brezniak
ADDRESS 470 Harvard St, Brookline

Received and filed NOV 14 1967 19....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
Male	white	MARRIED

11 If married, widowed, or divorced
HUSBAND of Beatrice Weiner
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 55 Years — Months — Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation Pharmacist
(Kind of work done during most of working life)

14 Industry or Business: Pharmacy

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) (State or country) Somerville Mass.

PARENTS

17 NAME OF FATHER Max Goldburgh

18 BIRTHPLACE OF FATHER (City) (State or country) Latvia

19 MAIDEN NAME OF MOTHER Bessie Pearlman

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Mrs. Beatrice Goldburgh
(Address) 117 Court Rd, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglano
(Signature of Agent of Board of Health or other)
Dir. of Public Health Nov 14, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 14 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

e filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused th.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

. Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 243

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Com. Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ingersoll Marie T. (McLAUGHLIN)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 34 Enfield Rd. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ..years..months 5 days. In place of residence 46 years – months – days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 13 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 20, 19 59, to Nov. 13, 1967, 19—
I last saw he alive on NOVEMBER 13, 1967, death is said to have occurred on the date stated above, at 10:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL HEMORRHAGE with LEFT HEMIPLEGIA	5 DAYS
Due To (b) HYPERTENSIVE & ARTERIO-SCLEROTIC HEART DISEASE	8 YRS
Due To (c) GENERALIZED ARTERIO-SCLEROSIS	10 YRS
OTHER SIGNIFICANT CONDITIONS CHRONIC CHOLECYSTITIS CHOLELITHIASIS	5 YRS.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

. Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & LAB.

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) M. Traunstein Jr. M. D.
M. TRAUNSTEIN JR. M.D.
(Print or Type Name)
(Address) 73 BARTLETT RD. WINTHROP, MASS Date Nov. 13, 1967

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL Nov 17, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St Winthrop

Received and filed NOV 16 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of David F Ingersoll
(Husband's name in full)

12 AGE 84 Years – Months – Days. If under 24 hours ..Hours..Minutes

13 Usual Occupation Homemaker
(Kind of work done during most of working life)

14 Industry or Business: AT Home

15 Social Security No. 010-24-4949 A

16 BIRTHPLACE (City) BOSTON (State or country) Mass

PARENTS

17 NAME OF FATHER William J McLaughlin

18 BIRTHPLACE OF FATHER (City) SANDWICH (State or country) MASS

19 MAIDEN NAME OF MOTHER MARY A OURLEY

20 BIRTHPLACE OF MOTHER (City) (State or country) ENGLAND

21 Informant MRS VIRGINA McGRATH
(Address) 34 ENFIELD RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip D. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health Nov. 16, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not meon mode of dying, h as heart failure, henia, etc. It meons disease, or compli-ions which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ing to death but not oted to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 244

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
WINTHROP COMMUNITY HOSPITAL
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANITA (COHEN) SADORF
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 24 FAUN BAR AVENUE St. WINTHROP (City or town and State)

Length of stay: In place of death ..... years 2 months 6 days. In place of residence 11 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1950, to Nov 14, 1967
I last saw he alive on Nov. 14, 1967, death is said to have occurred on the date stated above, at 2:40 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Carcinomatosis due — 1yr.
Due To (b) to Primary Carcinoma
Due To (c) of colon.

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical, Surgical, Pathological

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify ..... No

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 11/14/1967

6 TIFERETH ISRAEL of Winthrop, EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL NOV 16 1967

7 NAME OF FUNERAL DIRECTOR Philip BRISS
ADDRESS 470 HARVARD St. BROOKLINE

Received and filed NOV 15 1967 19..... John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOW

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of MURRAY SADORF
(Husband's name in full)

12 AGE 61 Years — Months — Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation SALES
(Kind of work done during most of working life)

14 Industry or Business: CLOTHING

15 Social Security No. 015-24-2707

16 BIRTHPLACE (City) NEW YORK
(State or country)

PARENTS

17 NAME OF FATHER SAMUEL COHEN

18 BIRTHPLACE OF FATHER (City) ENGLAND
(State or country)

19 MAIDEN NAME OF MOTHER ROSE LEVY

20 BIRTHPLACE OF MOTHER (City) NEW YORK
(State or country)

21 Informant Joseph Bloom
(Address) 82 SHARPE RD., Newton, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)
Director of Public Health 11/15/67
(Official Designation) (Date of Issue of Permit)

-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers
(City or Town making this return)

Registered No. 245

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)

No. Danvers State Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martin Weisberg
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent residence. No. 43 Hutchinson Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 28 years 5 months 0 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 30, 1961, to November 14, 1967
I last saw him alive on November 14, 1967 death is said to have occurred on the date stated above, at 7:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary occlusion	mins.
Due To (b)	Arteriosclerotic heart disease	yrs.
Due To (c)	Generalized arteriosclerotic	yrs.
OTHER SIGNIFICANT CONDITIONS	Diabetes mellitus	yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical&Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 11-15-67

6 Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 16, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh Funeral Home

ADDRESS Winthrop, Mass.

Received and filed NOV 27 1967, 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
male	white	single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 53 Years 1 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. None

16 BIRTHPLACE (City) Belmont
(State or country) Mass.

PARENTS

17 NAME OF FATHER George J. Weisberg

18 BIRTHPLACE OF FATHER (City) .....
(State or country) New York

19 MAIDEN NAME OF MOTHER Mary Davis

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) New Jersey

21 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED November 17, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

NOV 27 '67 AM

OFFICE OF THE TOWN CL
WINTHROP, MASS.

ORM R-301

for burial permit
ard of Health
Agent.

UCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
ave rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
ndition given

Med. Examiner notified — Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 246

1 PLACE OF DEATH: Suffolk (County)
Winthrop (City or Town)
No. 41 Shirley St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Thomas B Marshall (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W.W.1

(a) Residence. No. 41 Shirley St. Winthrop Mass
(Usual place of abode) (City or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV (Month) 16 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 3:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
Due To (b) natural causes, with history of amyotrophic
Due To (c) lateral sclerosis.

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS WINTHROP BOARD OF HEALTH
Charles Liberman MD

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 11/16/1967

6 Winthrop Winthrop Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 20 1967

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St, Winthrop

Received and filed NOV 20 1967 19.....
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Divorced

11 If married, widowed, or divorced
HUSBAND of Ellieen Hayes
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 71 Years 8 Months 19 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Constable
(Kind of work done during most of working life)

14 Industry or Business Town Of Winthrop

15 Social Security No. 033-07-4446

16 BIRTHPLACE (City) Melrose Mass
(State or country)

PARENTS

17 NAME OF FATHER Norman Kelley

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) unknown
(State or country)

21 Informant Mrs BarbaraHughes
(Address) 41 Shirley St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Director of Public Health 11/20/67
(Official Designation) (Date of Issue of Permit)

-934553

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... June 7 1917

DATE OF DISCHARGE ..... June 61921

RANK, RATING ..... Seaman 2nd Class

ORGANIZATION AND OUTFIT ..... Navy

SERVICE NUMBER ..... 141-73-32.

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 '67 AM

OFFICE OF ... CLERK
WINTHROP ...

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

*This does not mean
e mode of dying,
ch as heart failure,
thenia, etc. It means
e disease, or compli-
tions which caused
eath.*

*Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.*

*Conditions contrib-
ting to death but not
lated to the terminal
isease condition given
(a).*

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 247

1 PLACE OF DEATH
SUFFOLK (County)
Winthrop (City or Town)
No. Cliff House N. Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JEFFERSON D. GARDNER
(If deceased married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) W.W.1

(a) Permanent Residence. No. 205 Saratoga St. East Boston Mass
(City or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 50 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 19 - 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10, 1966, to Nov. 19, 1967
I last saw h. alive on NOV. 18, 1967 death is said to have occurred on the date stated above, at 5:25 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Bronchiectasis — 3 yrs

Due To (b) 0

Due To (c) 0

OTHER SIGNIFICANT CONDITIONS Paget's Disease

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Charles G. Ferrera M. D.
Charles G. Ferrera M.D.
(Print or Type Name)
(Address) 57 Bennington St. Date Nov. 19 1967

6 Mt. Hope Cemetery, Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 22, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed NOV 20 1967
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 74 Years 4 Months 15 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation Retired Watchman
(Kind of work done during most of working life)

14 Industry or Business: Warehouse

15 Social Security No. 028-10-6871

16 BIRTHPLACE (City) Charlestown P.E.I.
(State or country) Canada

PARENTS

17 NAME OF FATHER Jefferson Gardner

18 BIRTHPLACE OF FATHER (City) P.E.I.
(State or country) Canada

19 MAIDEN NAME OF MOTHER Jane Batt

20 BIRTHPLACE OF MOTHER (City) P.E.I.
(State or country) Canada

21 Informant John Gardner
(Address) 205 Saratoga St., East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Petrucciano M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health 11/20/67
(Official Designation) (Date of Issue of Permit)

DM-3-65-939763

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE June 24, 1918

DATE OF DISCHARGE Dec. 11, 1918

RANK, RATING Pvt.

ORGANIZATION AND OUTFIT 1st Co. 1st Rec. Bn. 151st Depot Brigade Army

SERVICE NUMBER 2726654

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or cbanged, or if tbe deceased bad retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
n Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not meon
mode of dying,
as heart failure,
enia, etc. It meons
diseose, or compli-
ns which coused
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onditions, if ony,
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ove cause (a),
ating the under-
ing cause last.

Conditions contrib-
g to death but not
ed to the terminal
se condition given
a).

-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 248

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME WILLIAM A. GRIMES (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 271 River Road St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..... years ..... months 10 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 11-19-67 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1960, to 11-19, 1967

I last saw him alive on 11-18, 1967, death is said to have occurred on the date stated above, at 6:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Uremia	
Due To (b) Chronic nephritis	6 mos
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? NO

What test confirmed diagnosis? B.U.N.

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify NO

(Signature) H.B. Greenfield, M. D.

H. B. Greenfield
(Print or Type Name)

(Address) 447 Shirley Winthrop Date 11-19 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 21, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 20 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): married

11 If married, widowed, or divorced HUSBAND of Christine McCarthy (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 88 Years 1 Months 4 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation retired postman (Kind of work done during most of working life)

14 Industry or Business: U.S. Post Office Dept.

15 Social Security No. none

16 BIRTHPLACE (City) Boston (State or country) Massachusetts

PARENTS

17 NAME OF FATHER Michael Grimes

18 BIRTHPLACE OF FATHER (City) Charlestown (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Sophie Burgess

20 BIRTHPLACE OF MOTHER (City) Charlestown (State or country) Massachusetts

21 Informant Mrs. William A. Grimes

(Address) 271 River Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Director of Public Health 11/20/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 '67 PM

OFFICE OF TOWN CLERK
WINTHROP, MASS.

FORM R-301

filed for burial permit
n Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
enia, etc. It means
disease, or compli-
ns which caused
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nditions, if any,
hich gave rise to
ove cause (a),
ating the under-
ing cause last.

Conditions contrib-
g to death but not
ed to the terminal
se condition given
a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 249

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 20 WAVE WAY St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME CEZIA (GOLDBERG) FOGEL
(If deceased is married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 20 WAVE WAY AVE St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death 58 years ..... months ..... days. In place of residence 58 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. (Month) 20 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1950, to NOV. 20, 1967
I last saw he alive on NOV. 18, 1967, death is said to have occurred on the date stated above, at 8:35 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arteriosclerotic Heart
Due To (b) Disease.
Due To (c)

INTERVAL BETWEEN ONSET AND DEATH 5yrs.

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M.D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 11/20/1967

6 TIFERETH ISRAEL of Winthrop, EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL NOV. 21 1967

7 NAME OF FUNERAL DIRECTOR TORI FUNERAL SERVICE INC
ADDRESS 157 WASHINGTON AVE CHELSEA

Received and filed NOV 20 1967 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE
9 COLOR WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of JOSEPH D. FOGEL (Husband's name in full)

12 AGE 82 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) LITHUANIA

PARENTS
17 NAME OF FATHER EPHRAAM. ISAAC GOLDBERG
18 BIRTHPLACE OF FATHER (City) (State or country) LITHUANIA
19 MAIDEN NAME OF MOTHER LIPPORAH (CBL)
20 BIRTHPLACE OF MOTHER (City) (State or country) LITHUANIA

21 Informant MISS FRANCES FOGEL (Address) 20 WAVE WAY AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health
(Official Designation)
Nov 20, 1967
(Date of Issue of Permit)

3-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 '67 PM

OFFICE OF TOWN CLERK
WINTHROP, MASS.

ORM R-301

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
ondition given

-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 250

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ethel Preble
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. (Usual place of abode) No. 10 Lowell Road, Winthrop, Mass. St. (City or town and State)

Length of stay: In place of death 0 years 2 months 27 days. In place of residence 25 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 25, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1967, to Nov. 25, 1967
I last saw her alive on November 24, 1967, death is said to have occurred on the date stated above, at 10.30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Metastatic Carcinoma	9 Mos.
Due To (b) Adenocarcinoma of Left Breast	6 Yrs.
Due To (c)	

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Pathology Report

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) John F. Collins M.D., M. D.
John F. Collins M.D.
(Print or Type Name)
(Address) Revere, Mass. Date Nov. 25, 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov 28, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 216 Winthrop St. Winthrop

Received and filed NOV 28 1967
John H. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F.
9 COLOR White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

11 If married, widowed or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Frederick P. Preble
(Husband's name in full)

12 AGE 69 Years — Months — Days — If under 24 hours Hours Minutes

13 Usual Occupation House wife
(Kind of work done during most of working life)

14 Industry or Business Home

15 Social Security No. 011-01-7752 B

16 BIRTHPLACE (City) Southbridge Mass
(State or country)

PARENTS

17 NAME OF FATHER Michael Kelly

18 BIRTHPLACE OF FATHER (City) Jamaica Plain Mass
(State or country)

19 MAIDEN NAME OF MOTHER Sarah Beals

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Frederick P. Preble
(Address) 10 Lowell Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 11/28/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

28 '67 PM
OFFICE CLERK

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused th.

Conditions, if any, which gave rise to bove cause (a), tating the under- ying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 251

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP, MASS (City or Town)
No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GERTRUDE J. (WALSH) CROWLEY
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 43 Loring Rd., Winthrop Mass.
(City or town and State)

Length of stay: In place of death — years — months 10 days. In place of residence 20 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1967, to Nov. 26, 1967
I last saw he alive on Nov. 25, 1967, death is said to have occurred on the date stated above, at 6:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Coronary occlusion — min's
Due To
(b) Arteriosclerosis-gen — yrs
Due To
(c)
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart disease — yrs

Was autopsy performed? no
What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE
(Print or Type Name)
(Address) 194 Washington Ave Date Nov. 26 1967

6 Place of Burial or Cremation Winthrop Cem. Winthrop (City or Town)
DATE OF BURIAL Nov 29 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St.

Received and filed NOV 29 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR white
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William F. Crowley
(Husband's name in full)

12 AGE 79 Years — Months — Days
If under 24 hours Hours Minutes

13 Usual Occupation House wife
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. 013-07-3523-A

16 BIRTHPLACE (City) East Boston
(State or country)

PARENTS

17 NAME OF FATHER Thomas A Walsh

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Murray

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country)

21 Informant Mrs. Robert Remming
(Address) 18 Tamarack Rd Medford

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 11/29/67
(Official Designation) (Date of Issue of Permit)

1-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 29 '67 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean the mode of dying, uch as heart failure, sthenia, etc. It means he disease, or compli-ations which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-ting to death but not elated to the terminal isease condition given n (a).

Medical Examiner Declines Jurisdiction

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 253

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Fannie Alean Swift(Whittle)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 192 Bartlett Road St.
(City or town and State)

Length of stay: In place of death years 3 months days. In place of residence 4 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1967, to Nov 26, 1967
I last saw h[illegible] alive on Nov 26, 1967 death is said to have occurred on the date stated above, at 10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS fracture hip 7-26-67

INTERVAL BETWEEN ONSET AND DEATH 2 days

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) H B Greenfield, M. D.
(Print or Type Name)
(Address) 947 Shirley St Winthrop Date 11-26 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 29, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 28 1967
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Ralph Aloysius Swift
(Husband's name in full)

12 AGE 82 Years 5 Months 16 Days
If under 24 hours Hours Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 017-40-3740 J.I.

16 BIRTHPLACE (City) Chelsea
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Charles Phillip Whittle

18 BIRTHPLACE OF FATHER (City) Charlestown
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Helen M. Blaisdell

20 BIRTHPLACE OF MOTHER (City)
(State or country) Maine

21 Informant Paul Swift
(Address) 192 Bartlett Road

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 11/28/67
(Official Designation) (Date of Issue of Permit)

OM-3-65-939763

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 29 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE AUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean he mode of dying, uch as heart failure, sthenia, etc. It means he disease, or compli-ations which caused eath.

Conditions, if any, which gave rise to above cause (a), stating the under-lying cause last.

Conditions contrib-uting to death but not elated to the terminal isease condition given n (a).

T. LEBANON

OM-3-65-939763

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 253

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Samuel Aloff
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 14 GLENARM ST. St. DORCHESTER (City or town and State)

Length of stay: In place of death.....years.....months....21 days. In place of residence....2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 27, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug, 1966, to Nov. 27, 1967
I last saw him alive on 11/27, 1967, death is said to have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

Due To (b) with acute pulmonary edema — 1 hr.

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Myron N. King, M. D.
Myron N. King M.D.
(Print or Type Name)
(Address) 22 Glenarm St. Winthrop Mass. Date 11/27, 1967

6 Place of Burial or Cremation SHARO TIFILO WEST ROXBURY (City or Town)
DATE OF BURIAL NOV. 28, 1967

7 NAME OF FUNERAL DIRECTOR ROBERT LeVine
ADDRESS 1668 BEACON ST. BROOKLINE

Received and filed NOV 28 1967, 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of BLANCHE NESS
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 83 years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation CARPENTER - RETIRED
(Kind of work done during most of working life)

14 Industry or Business: SELF- EMPLOYED

15 Social Security No. 029-05-0680

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS
17 NAME OF FATHER MOISHE ALOFF
18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA
19 MAIDEN NAME OF MOTHER ASNER
20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MRS. ROSE ABRAMSON
(Address) 24 DOLPHIN AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 11/28/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 28 '67 PM
CLERK

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

INT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not meon
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as heart foilure,
enia, etc. It means
disease, or compli-
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Conditions contrib-
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8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 254

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Isabel (Woodring) Zehringer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 20 Chester Ave. St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ..years..months 21 days. In place of residence 53 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 28 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1, 1953, to November 28, 1967

I last saw her alive on November 28, 1967, death is said to have occurred on the date stated above, at 9:00a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Bilateral bronchopneumonia	2 wks.
Due To (b)	Fractured left hip & left humerus	7 wks.
Due To (c)	Arteriosclerotic & hypertensive heart disease	12 yrs.
OTHER SIGNIFICANT CONDITIONS	Pernicious anemia	15 yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein Jr. M.D., M. D.
M. Traunstein, Jr. M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop, Mass. Date 11-28 1967

6 Place of Burial or Cremation: Newton Cemetery (City or Town) Newton

DATE OF BURIAL Nov. 30 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed NOV 29 1967 19..

John E Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widow

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John Zehringer
(Husband's name in full)

12 AGE 97 Years 9 Months 23 Days | If under 24 hours ..Hours..Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 012-38-3896

16 BIRTHPLACE (City) Columbus Junction
(State or country) Iowa

PARENTS

17 NAME OF FATHER: James Woodring

18 BIRTHPLACE OF FATHER (City)
(State or country) Pennsylvania

19 MAIDEN NAME OF MOTHER: Sarah Roth

20 BIRTHPLACE OF MOTHER (City)
(State or country) Pennsylvania

21 Informant: Victoria Snow
(Address) Epping New Hampshire

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 11/29/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 29 '67 PM
OFFICE OF THE TOWN CLERK
WINTHROP MASS

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
enia, etc. It means
disease, or compli-
ons which caused
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onditions, if any,
hich gave rise to
bove cause (a),
ating the under-
ing cause last.

Conditions contrib-
g to death but not
ted to the terminal
ase condition given
a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) — WINTHROP (City or Town)

WINTHROP (City or Town making this return)

Registered No. 255

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SUZANNE AUGEREAU (Delmouly)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 20 SAGAMORE AVENUE ~~St.~~ WINTHROP, MASSACHUSETTS (City or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 1 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 29 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from January, 1967, to Nov. 29, 1967

I last saw her alive on November 29 1967, death is said to have occurred on the date stated above, at 9:39 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia (Terminal)	one day
Due To (b) Cirrhosis of liver	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerosis	yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph Gregorie, M. D.
JOSEPH GREGORIE
(Print or Type Name)
(Address) 194 Washington St. Date Nov. 29 1967

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 2, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed DEC 1 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Armand Augereau (Husband's name in full)

12 AGE 69 Years 1 Months 18 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) Paris (State or country) France

PARENTS

17 NAME OF FATHER Theophile Delmouly

18 BIRTHPLACE OF FATHER (City) ..... (State or country) France

19 MAIDEN NAME OF MOTHER Irene Majouffet

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) France

21 Informant Simone I. Carrozza
(Address) 20 Sagamore Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health 12/1/67
(Official Designation) (Date of Issue of Permit)

8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 1 '67 PM

CLERK

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenio, etc. It means e disease, or compli-tions which caused oth.

Conditions, if any, which gove rise to above cause (a), stoting the under-lying couse last.

Conditions contrib-ing to death but not loted to the terminal seose condition given (a).

M-9-65-941327

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop, Mass.
(City or Town making this return)

Registered No. 256

1 PLACE OF DEATH
Suffolk
(County)
Winthrop, Mass.
(City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Isaac Liebert
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 48 Shawmut Street, Revere, Mass. St. (City or town and State)

Length of stay: In place of death ..years..months 7 days. In place of residence 35 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1965, to NOV. 30, 1967. I last saw him alive on NOV. 30, 1967, death is said to have occurred on the date stated above, at 8:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebrovascular Coclusion	3 days
Due (b) Cerebral Arteriosclerosis and	2yrs.
Due To (c) Rt. Hemiplegia	
OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease and Congestive Failure	2yrs

Was autopsy performed? NO
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Charles Liberman, M. D.
(Print or Type Name) Charles Liberman
(Address) WINTHROP, MASS Date 11/30/ 1967

6 Place of Burial or Cremation SHARON MEM. PK. SHARON MASS (City or Town)
DATE OF BURIAL DEC. 3 1967 19..

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV.
ADDRESS 1615 BEACON ST BROOKLINE

Received and filed DEC 1 1967 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of CAROLINE (BRADFORD)
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 79 Years..Months..Days. If under 24 hours ..Hours..Minutes

13 Usual Occupation MEAT CUTTER RETIRED
(Kind of work done during most of working life)

14 Industry or Business: FOOD

15 Social Security No. 011-01-3832

16 BIRTHPLACE (City) LITHUANIA
(State or country)

PARENTS

17 NAME OF FATHER BERNARD LIEBERT

18 BIRTHPLACE OF FATHER (City)
(State or country) LITHUANIA

19 MAIDEN NAME OF MOTHER CBL

20 BIRTHPLACE OF MOTHER (City)
(State or country) LITHUANIA

21 Informant ROBERTA COLLINS
(Address) 108GRANDVIEW AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vetzgham M.D.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 12/1/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 1 '67 PM

OFFICE Cr ... CLERK
WINTH... MASS

REVERE NOTIFIED - 12-8-67

I R-301A

RUCTIONS FOR CERTIFICATE

giving OF DEATH

ot enter than one for each (b) and (c)

loes not mean e of dying, heart failure, etc. It means e, or compli- which caused

ns, if any, ave rise to cause (a), the under- cause last.

ions contrib- death but not the terminal ondition given

Chapter 137, 1954, requires ns to print or e cause or of death on rtificates.

50M-1-68-921376

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP 257

To be filed for burial permit with Board of Health or its Agent.

Registered No. _____

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Laura E. Broussard
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 30 Pauline St., St. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ____ years 2 months ____ days. In place of residence 40 years ____ months ____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 1 (Day) 1967 (Year)

4 I HEREBY CERTIFY. That I attended deceased from July, 1967, to Dec 1, 1967
I last saw her alive on Dec. 1, 1967, death is said to have occurred on the date stated above, at 11:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Right Breast — INTERVAL BETWEEN ONSET AND DEATH: 2yrs

Due To (b) with metastasis

Due To (c) _____

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis Clinical. Surgical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____

(Signed) Charles Liberman CHARLES LIBERMAN, M. D.
(Address) WINTHROP, MASS Date Dec. 1, 1967

6 Place of Burial or Cremation St. Joseph's (City or Town) Boston, Mass
DATE OF BURIAL December 4, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed DEC 4 1967 19__
John A Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of _____ (Give maiden name of wife in full)
(or) WIFE of Charles Broussard (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years ____ Months ____ Days — If under 24 hours ____ Hours ____ Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. _____

16 BIRTHPLACE (City) East Boston (State or country) Mass

PARENTS

17 NAME OF FATHER William Lynch

18 BIRTHPLACE OF FATHER (City) _____ (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Smith

20 BIRTHPLACE OF MOTHER (City) _____ (State or country) New York

21 Informant Margaret Lynch
(Address) 119 Upland Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (?)
(Signature of Agent of Board of Health or other)
Dir of Public Health 12/4/67
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ....— General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

MX

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

*This does not mean
e mode of dying,
h as heart failure,
henia, etc. It means
e disease, or compli-
ions which caused
ath.*

*Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.*

*Conditions contrib-
ing to death but not
ated to the terminal
ease condition given
(a).*

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 258

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elizabeth Doggett
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 805 East Broadway St. South Boston, Mass.
(City or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 85 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 6 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1967, to DEC 6, 1967

I last saw h. alive on DEC 5, 1967, death is said to have occurred on the date stated above, at 5 55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL VASCULAR THROMBOSIS AND UREMIA	1½ DAYS
Due To (b) ARTERIO-SCLEROTIC HEART DIS. HYPERTENSIONS	2 YRS.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS OLD CVA C RT HEMIPLEGIA	13 mo.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & LABORATORY

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 22 PLEASANT ST. WINTHROP MASS. Date 12/6 1967

6 Place of Burial or Cremation: Fairview Cemetery, Boston, Mass. (City or Town)

DATE OF BURIAL December 8 1967

7 NAME OF FUNERAL DIRECTOR Arthur L. Rockwell

ADDRESS 195 Mt. Auburn St., Watertown, Mass.

Received and filed DEC 7 1967 19....

John A. Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 85 Years 1 Months 7 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Registered Nurse
(Kind of work done during most of working life)

14 Industry or Business: Boston City Hospital

15 Social Security No. 015-38-1439

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER: Frederick F. Doggett

18 BIRTHPLACE OF FATHER (City) Barnstable, (State or country) Mass.

19 MAIDEN NAME OF MOTHER: Mary C. DeWolf

20 BIRTHPLACE OF MOTHER (City) Cambridge, (State or country) Mass.

21 Informant: Arthur L. Doggett
(Address) 51 Adams Ave., Watertown, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 12/7/67
(Official Designation) (Date of Issue of Permit)

JURISDICTION

MEDICAL EXAMINER DECLINED

M-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 7 '67 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

*This does not mean
e mode of dying,
ch as heart failure,
hemia, etc. It means
e disease, or compli-
tions which caused
ath.*

*Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.*

*Conditions contrib-
ing to death but not
ated to the terminal
ease condition given
(a).*

Reported to Med. Examiner

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 259

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Anastasios Panagiotopolos
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR): No

(a) Permanent Residence. No. 308 Bowdoin St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months....1....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Dec (Month) 8 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 1:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
Due To (b) to natural causes.
Due To (c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS: Charles Liberman MD

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? NO
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify .....

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 12/9/ 1967

6 Winthrop Cemetery Winthrop Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec 11 1967

7 NAME OF FUNERAL DIRECTOR Paul K Babalas
ADDRESS 336 Broadway Camb Mass

Received and filed DEC 11 1967 19.....
John A Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Sophie Papouleas
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 85 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Fruit Dealer
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 028-28-7410 A

16 BIRTHPLACE (City) (State or country): Greece

PARENTS

17 NAME OF FATHER: can not be learned
18 BIRTHPLACE OF FATHER (City) (State or country): Greece
19 MAIDEN NAME OF MOTHER: can not be learned
20 BIRTHPLACE OF MOTHER (City) (State or country): Greece

21 Informant: Sophie Panagiotopolos
(Address) 308 Bowdoin St Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglianoni
(Signature of Agent of Board of Health or other)
Dir of Public Health 12/11/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 11 '67 PM

OFFICE OF TH...
WINTHR...

R-301A

UCTIONS
OR
CERTIFICATE

giving
OF DEATH

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tc. It means
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the terminal
ndition given

Chapter 137,
954, requires
s to print or
cause or
death on
ificates.

The Commonwealth of Massachusetts

Kevin H. White
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
To be filed for burial permit with Board of Health or its Agent.

Registered No. 260

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)

No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Effie L. Briggs (Fales)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 25 Corey St. St. Charlestown
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ___ months ___ days. In place of residence 30 years ___ months ___ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 13 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan., 1968, to Dec. 13, 1967
I last saw her alive on Dec. 13, 1967, death is said to have occurred on the date stated above, at 10:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Hypertensive and Arterio-Sclerotic Heart Disease	5yrs.
Due To (b) with congestive failure.	2yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Anemia, Hypochromic	1yr.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

CHARLES LIBERMAN
(Signed) Charles Liberman, M. D.
(Address) WINTHROP, MASS Date 12/13/1967

6 Glenwood Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 15 1967

7 NAME OF FUNERAL DIRECTOR David Fudge & Son Inc.
ADDRESS 100 Highland Ave. Somerville

Received and filed DEC 15 1967 19
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Roland Briggs
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 5 Months 5 Days — If under 24 hours ___ Hours ___ Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 010-22-5610

16 BIRTHPLACE (City) Everett
(State or country) Mass

PARENTS

17 NAME OF FATHER Isaac Fales

18 BIRTHPLACE OF FATHER (City) CNBL
(State or country) CNBL

19 MAIDEN NAME OF MOTHER Julia Stromach

20 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) CNBL

21 Informant Marion E. Poor
(Address) 49 Beechwood Rd. Sudbury, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano M.D.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 12/15/67
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.... — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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OFFICE OF
WINTHROP

1st City notified 1-8-68

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 261

1 PLACE OF DEATH: SUFFOLK (County)
WINTHROP (City or Town)

Viking Nursing Home

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LEONA ELLIS (TRAVERS)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 252 NORTH WEST 2ND St. MIAMI FLA.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years 4 months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC (Month) 14 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JULY 1, 1967, to DEC 14, 1967
I last saw her alive on DEC 12, 1967, death is said to have occurred on the date stated above, at 7:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE MYOCARDIAL INFARCTION	2°
Due To (b) ARTERIO-SCLEROTIC & HYPERTENSIVE HEART DIS	2 YRS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 22 PLEASANT ST WINTHROP MASS Date DEC 15 1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL DEC 16 1967

7 NAME OF FUNERAL DIRECTOR BISBEE & SONS
ADDRESS 549 LINCOLN AVE SAUGUS

Received and filed DEC 15 1967 19
John A Clare
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of JOSEPH ELLIS
(Husband's name in full)

12 AGE 76 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation ENTERTAINER
(Kind of work done during most of working life)

14 Industry or Business CIRCUS

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER JOSEPH TRAVERS

18 BIRTHPLACE OF FATHER (City) PROVINCETOWN
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY WHALEN

20 BIRTHPLACE OF MOTHER (City) CAPE BRITTON
(State or country) N. S.

21 Informant MRS JAMES HUSBAND
141 CENTRAL ST.
(Address) SAUGUS MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)
Director of Public Health 12/15/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 15 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

Fla notified 1-8-68

xt

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR EDICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused th.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 262

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Viking Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maria Rosatto (COGORNO)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 115 Leyden St St. East Boston
(City or town and State)

Length of stay: In place of death ....years 8 months ....days. In place of residence 50 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 15 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May, 1967, to Dec. 15, 1967. I last saw deceased alive on Dec. 15, 1967, death is said to have occurred on the date stated above, at 1:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebro-Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 30 min
Due To (b) arterio sclerosis gen. — yrs
Due To (c) — yrs

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus — yrs

Was autopsy performed? ....
What test confirmed diagnosis? ....

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) [illegible], M. D.
Joseph [illegible]
(Print or Type Name)
(Address) [illegible] Date 12-15 1967

6 Place of Burial or Cremation Woodlawn Cemetery (City or Town) Everett
DATE OF BURIAL 12/18/ 1967

7 NAME OF FUNERAL DIRECTOR Raymond F. Cutillo
ADDRESS 773 Broadway Revere

Received and filed DEC 15 1967 19....
John A. Clare (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Lewis Rosatto
(Husband's name in full)

12 AGE 70 Years 4 Months 2 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Housewife

15 Social Security No. NO

16 BIRTHPLACE (City) (State or country) Italy

PARENTS
17 NAME OF FATHER ? COGORNO
18 BIRTHPLACE OF FATHER (City) (State or country) Unknown
19 MAIDEN NAME OF MOTHER
20 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

21 Informant John Rosatto
(Address) 68 St Andrew Rd E13

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (R)
(Signature of Agent of Board of Health or other)
Director of Public Health 12/15/67
(Official Designation) (Date of Issue of Permit)

1-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 15 '67 PM

OFFICE OF ... CLERK
WINTH...

R-303

r burial permit
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information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-93638

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 263

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
Enroute to Winthrop Community Hospital
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME GERALD COHEN
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 17 Hutchinson Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 19 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 16, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cranio-facial traumatic injury.
crushing injury of chest.
Fracture of femur and pelvis.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury December 16, 19 67
IF ACCIDENTAL, was injury causally related to the death? ....
Where did Injury occur? Winthrop, Massachusetts
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Public highway
(Specify type of place)
Manner of Injury Passenger in automobile
(How did injury occur?)
Nature of Injury which collided with oil truck.
While at work? ....Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? ....
If so, state ....
(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)
(Address) Boston Date 12/17 19 67

7 SHARON MEM PK. SHARON
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Dec 18 19 67

8 NAME OF FUNERAL DIRECTOR TORF Funeral Service
ADDRESS 1615 BEACON ST BROOKLINE

Received and filed DEC 18 1967 19....
John A Clare
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
MALE	WHITE	SINGLE

12 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

13 AGE 19 Years....Months....Days | If under 24 hours ....Hours....Minutes

14 Usual Occupation: STUDENT
(Kind of work done during most of working life)

15 Industry or Business: STUDENT

16 Social Security No. 032-38-8345

17 BIRTHPLACE (City) (State or country) WINTHROP MASS

PARENTS

18 NAME OF FATHER Robert S Cohen

19 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass

20 MAIDEN NAME OF MOTHER MILDRED LEVY

21 BIRTHPLACE OF MOTHER (City) (State or country) Boston Mass

22 Informant Mr Robert Cohen
(Address) 17 Hutchinson ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G Vitaglione M.D.
(Signature of Agent of Board of Health or other)
Div. of Public Health 12/18/67
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

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The Commonwealth of Massachusetts

~~EDWARD J. CRONIN~~ Kevin H. White

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP

To be filed for burial permit with Board of Health or its Agent.

Registered No. 264

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)

No. Viking Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME AGNES J. BROWN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 73 Loring Road St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 6 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 18, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1958, to Dec. 18, 1967
I last saw her alive on Dec. 18, 1967, death is said to have occurred on the date stated above, at 1:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Generalized Arterio sclerosis and	2yrs
Due To (b) Cerebral arteriosclerosis	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Cyst Right Kidney	5yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical, Surgical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) CHARLES H. LIBERMAN M.D. M. D.
(Address) WINTHROP, MASS Date 12/18/1967

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 21, 1967 19

7 NAME OF FUNERAL DIRECTOR Porcella Funeral Ser.
ADDRESS 876 Winthrop Ave., Revere

Received and filed DEC 20 1967 19
John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Patrick J. Brown
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 0 Months 6 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Gloucester
(State or country) Mass.

PARENTS

17 NAME OF FATHER William Malloy

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Katherine Power

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Ruth E. Collins
(Address) 73 Loring Rd., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (3)
(Signature of Agent of Board of Health or other)
Dir of Public Health 12/20/67
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

DEC 20 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

JM

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean e mode of dying, ch as heart failure, thenia, etc. It means e disease, or compli- tions which caused ath.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ing to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 265

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 14 Hermon St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hilary T. Minton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW #1

(a) Permanent Residence. No. 15 Read St., St. (City or town and State)

Length of stay: In place of death ..... years ..... months — days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 18, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from MAR 28, 1967, to DEC 18, 1967
I last saw him alive on DEC 11, 1967, death is said to have occurred on the date stated above, at 12:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE MYOCARDIAL INFARCTION	10 MIN
Due To (b) ARTERIO-SCLEROTIC HEART DIS	2 YRS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 111 PLEASANT ST WINTHROP MASS Date DEC 19 1967

6 St. Joseph's Boston, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 21, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed DEC 20 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Anna A. Flynn (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 77 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Retired Ass't Supt. (Kind of work done during most of working life)

14 Industry or Business: U.S.Gen Ser Adm

15 Social Security No. 030-09-7353 A

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Richard Minton

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Sarah McDonald

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

21 Informant Anna Minton
(Address) 15 Read St.,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (B)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 12/20/67
(Official Designation) (Date of Issue of Permit)

-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 4-26-18

DATE OF DISCHARGE 1-8-19

RANK, RATING ..... Pvt

ORGANIZATION AND OUTFIT ..... Army

SERVICE NUMBER 1 691 377

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 20 '67 PM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Foxborough (City or Town making this return)

Registered No. 266

1 PLACE OF DEATH: Norfolk (County); Foxborough (City or Town)

No. Foxborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Flossie Moore (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 80 Reed St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death 23 years 11 months 17 days. In place of residence Undetermined years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: December (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from December 12, 1943 to December 19, 1967

I last saw her alive on December 18, 1967, death is said to have occurred on the date stated above, at 1:30 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bronchopneumonia	10 days
Due To (b)	
Due To (c) Fracturer patella left	2 mos.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clin.-lab. findings

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Michulan Bazan, M. D.

(Address) Foxborough, Mass. Date Dec. 19 1967

6 Place of Burial or Cremation: Winthrop Cemetery (City or Town) Winthrop, Mass.

DATE OF BURIAL December 21 1967

7 NAME OF FUNERAL DIRECTOR: Howard S. Reynolds

ADDRESS 160 Winthrop St., Winthrop, Mass.

Received and filed January 2, 1968

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 81 Years 1 Months 7 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Librarian (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop (State or country) Massachusetts

PARENTS

17 NAME OF FATHER: Eli Moore

18 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country) Newfoundland

19 MAIDEN NAME OF MOTHER: Cassie J. Morrow

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country) Prince Edward Island

21 Informant: Foxborough State Hospital Records

(Address) Foxborough, Mass.

A TRUE COPY

ATTEST: Mildred J. Shannon - Agent Board of Health (Registrar of City or Town where death occurred)

DATE FILED 12-19-67 19

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JAN -2 '68 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

his does not mean
mode of dying,
h as heart failure,
henia, etc. It means
disease, or compli-
ions which caused
th.

Conditions, if any,
which gave rise to
bove cause (a),
tating the under-
ying cause last.

Conditions contrib-
ng to death but not
ted to the terminal
ase condition given
(a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 267

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

Winthrop (City or Town making this return)

No. 297 Bowdoin Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dorothy Carmichael
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 297 Bowdoin St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 17 years months days. In place of residence 17 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 20 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1964, to Dec. 20, 1967
I last saw he alive on Dec. 17, 1967, death is said to have occurred on the date stated above, at 10:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Coronary Occlusion	1 day
Due To (b) Hypertensive Arterio-	4yrs.
Due To (c) Sclerotic Heart Disease	
OTHER SIGNIFICANT CONDITIONS Pernicious Anemia	6yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 12/20/ 1967

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop, Mass. (City or Town)
DATE OF BURIAL December, 22, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed DEC 21 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Reginald Carmichael
(Husband's name in full)

12 AGE 72 Years 9 Months 24 Days — If under 24 hours Hours Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 020-10-4057

16 BIRTHPLACE (City) Warren
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Patrick O'Donnell

18 BIRTHPLACE OF FATHER (City) North Hampton
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mathilde Guertin

20 BIRTHPLACE OF MOTHER (City) Spencer
(State or country) Massachusetts

21 Informant Mrs. Arthur Didham
(Address) 1140 Main St. Reading, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitaglione (?)
(Signature of Agent of Board of Health or other)
Director of Public Health 12/21/67
(Official Designation) (Date of Issue of Permit)

-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

21 '67 PM

OFFICE OF
WINT

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean mode of dying, h as heart failure, nenia, etc. It means disease, or compli- ons which caused th.

onditions, if any, hich gave rise to bove cause (a), tating the under- ying cause last.

Conditions contrib- g to death but not ted to the terminal ase condition given (a).

-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 268

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gallant, Helena M. (LEAVITT)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 122 Court Road St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death ..... years 1 months 7 days. In place of reside 2 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 23 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov-17, 1967, to DEC 23, 1967

I last saw her alive on DEC 23 1967, death is said to have occurred on the date stated above, at 1 55 p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE PULMONARY EMBOLUS	5 MIN
Due To (b) CARCINOMA OF COLON	2 MO.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS ARTERIO-SCLEROTIC HEART DIS	1 YR.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-RAY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N King, M. D.
MYRON N. KING MD
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date DEC 23 1967

6 CALVERY SOUTH PORTLAND ME.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 27 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP. MASS.

Received and filed DEC 27 1967 19

John A. Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): DIVORCED

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of HENRY GALLANT
(Husband's name in full)

12 AGE 77 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation CLERK.
(Kind of work done during most of working life)

14 Industry or Business: DEPARTMENT STORES

15 Social Security No. 004-40-6540 A

16 BIRTHPLACE (City) PORTLAND
(State or country) MAINE

PARENTS

17 NAME OF FATHER CHARLES LEAVITT.

18 BIRTHPLACE OF FATHER (City) BRUNSWICK.
(State or country) MAINE.

19 MAIDEN NAME OF MOTHER NELLIE KAVANAUGH

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) MAINE

21 Informant MRS DORIS PIECEWICZ

(Address) 122 COURT RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 12-27-67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
ard of Health
Agent.

TRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

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etc. It means
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cause (a),
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cause last.

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death but not
o the terminal
condition given

62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 269

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Laura Louise White (Keife)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 12 Sewall Avenue St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 9 months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 23 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN., 1960, to Dec. 23, 1967.
I last saw her alive on Dec. 22, 1967, death is said to have occurred on the date stated above, at 9:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Pneumonia — 8 days
Due To
(b) and Cerebrovascular Contusion — 10 days
Due To
(c) with left hemiparesis.
OTHER SIGNIFICANT CONDITIONS Cerebral Arteriosclerosis — 5 yrs; Hypertension — 7 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN MD
(Print or Type Name)
(Address) WINTHROP, MASS. Date 12/23/1967

6 Cambridge Cemetery, Cambridge
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 28, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop

Received and filed DEC 28 1967
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Frederick Burnham White
(Husband's name in full)

12 AGE 87 Years 6 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation housework
(Kind of work done during most of working life)

14 Industry or Business own home

15 Social Security No. none

16 BIRTHPLACE (City) Souris
(State or country) Prince Edward Island

PARENTS

17 NAME OF FATHER John Keife

18 BIRTHPLACE OF FATHER (City)
(State or country) Prince Edward Island

19 MAIDEN NAME OF MOTHER Louise MacCallun

20 BIRTHPLACE OF MOTHER (City)
(State or country) Prince Edward Island

21 Informant Orrin F. B. White, Jr.
(Address) 114 Fenway, Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip A. Vitaglione (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 12-28-67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR DICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each f (a), (b) and (c)

his does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ans which caused th.

Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.

Conditions contrib- ng to death but not ted to the terminal ase condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP (City or Town making this return)

Registered No. 270

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Palais, Ethel (Ziegler)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 53 Trident Ave, Winthrop St. (City or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 35 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 24 (Day) 1967 (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN, 1952, to Dec. 24, 1967

I last saw he alive on Dec. 24, 1967, death is said to have occurred on the date stated above, at 11:55 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion	1 day
Due To (b) Arteriosclerotic Heart	1 yr
Due To (c) Disease	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	8 yrs
RHEUMATOID ARTHRITIS	10 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 12/24/1967

6 TIFERETH ISRAEL OF WINTHROP, EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL DECEMBER 26 1967

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV., INC.
ADDRESS 1615 BEACON ST., BROOKLINE

Received and filed DEC 26 1967 19....

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of WILLIAM PALAIS
(Husband's name in full)

12 AGE 82 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER BENJAMIN ZIEGLER)

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER NELLIE (PALAIS)

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MRS. ALICE PHILLIPS (SISTER)
(Address) 99 PURITAN LANE, SWAMPSCOTT

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health 12/26/67
(Official Designation) (Date of Issue of Permit)

-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 26 '67 PM
WN CLERK
MASS.

FORM R-301

filed for burial permit th Board of Health or its Agent.

INSTRUCTIONS FOR DICAL CERTIFICATE

RINT OR TYPE USE OR CAUSES OF DEATH

do not enter more than one cause for each (a), (b) and (c)

his does not mean mode of dying, h as heart failure, enia, etc. It means disease, or compli- ons which caused th.

onditions, if any, hich gave rise to bove cause (a), toting the under- ying cause last.

Conditions contrib- g to death but not ted to the terminal ose condition given (a).

Medical Examiner Notified Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 271

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 31 Undine Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hugh McKenzie Hewitt
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Permanent Residence. No. 31 Undine Avenue St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 1 years ..... months ..... days. In place of residence 1 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 25 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 11:00 P. m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes, presumably

Due To (c) acute coronary occlusion on basis of history.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman MD

Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 12/28/ 19 67

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 29, 1967 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop

Received and filed DEC 29 1967 19.....
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) widowed

11 If married, widowed, or divorced
HUSBAND of Marion Virginia Sanborn
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 61 Years 2 Months 8 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation salesman
(Kind of work done during most of working life)

14 Industry or Business: Frozen Food Co.

15 Social Security No. 029-12-4100

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Hugh McKenzie Hewitt

18 BIRTHPLACE OF FATHER (City) Green Harbor
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Minnie Kean

20 BIRTHPLACE OF MOTHER (City) Jordan Bay
(State or country) Nova Scotia

21 Informant Mrs. Leonard R. Sundberg
(Address) 20 Shirley St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67
(Official Designation) (Date of Issue of Permit)

7-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
DICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
h as heart failure,
enia, etc. It means
disease, or compli-
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onditions, if any,
hich gave rise to
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ying cause last.

Conditions contrib-
g to death but not
ted to the terminal
ase condition given
(a).

-8-66-943275

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 272

1 PLACE OF DEATH
Suffolk (County)
WINTHROP (City or Town)
No. BAY VIEW NURSING Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME ESTHER BINDER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 16 Sixth St St. Chelsea (City or town and State)

Length of stay: In place of death ..years 11 months ..days. In place of residence 60 years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 26 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-31, 1966, to 12-26, 1967
I last saw h. alive on 12-25, 1967, death is said to have occurred on the date stated above, at 8:00 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction
Due To (b) arteriosclerosis
Due To (c) diabetes
OTHER SIGNIFICANT CONDITIONS uremia

INTERVAL BETWEEN ONSET AND DEATH
(a) 1 day
(b)
(c)

Was autopsy performed? No
What test confirmed diagnosis? –

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify No

(Signature) H.B. Greenfield, M. D.
(Print or Type Name)
(Address) 741 Shirley St Winthrop Date 12-26 1967

6 Place of Burial or Cremation KNIGHTS of Liberty Woburn (City or Town)
DATE OF BURIAL Dec 28 1967

7 NAME OF FUNERAL DIRECTOR TORI Funeral Service
ADDRESS 151 Washington Ave Chelsea

Received and filed DEC 28 1967 19..
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Fem
9 COLOR White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) WIDOW

11 If married, widowed, or divorced
HUSBAND of ..
(Give maiden name of wife in full)
(or) WIFE of JOSEPH BINDER
(Husband's name in full)

12 AGE 88 Years ..Months ..Days
If under 24 hours ..Hours ..Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS
17 NAME OF FATHER ABRAHAM KALLMAN
18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA
19 MAIDEN NAME OF MOTHER BRANDYL
20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant HARRY BINDER
(Address) 7 Stonehill Rd Stoneham

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Philip G. Vitagliano (Mack)
(Signature of Agent of Board of Health or other)
Director of Public Health 12-27-67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean ie mode of dying, ich as heart failure, thenia, etc. It means ie disease, or compli- ations which coused eath.

Conditions, if any, which gove rise to above couse (o), stating the under- lying couse lost.

Conditions contrib- ting to death but not lated to the terminal isease condition given s (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) — WINTHROP (City or Town)

WINTHROP (City or Town making this return)

Registered No. 273

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY R. MOONEY (NEE MARY R. McCULLOCH) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 465 BOULEVARD St. REVERE, MASSACHUSETTS (City or town and State)

Length of stay: In place of death ..... years ..... months 16 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 26 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/11/67 19..., to 12/26/67, 19..., I last saw her alive on 12/26/67, 19..., death is said to have occurred on the date stated above, at 9 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cardiovascular collapse	hours,
Due To (b) Carcinomatosis	days
Due To (c) Carcinoma of bowel	months
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Nicholas A. Casaburi, M. D.
Nicholas A. Casaburi MD
(Print or Type Name)

(Address) 81 Revere St. Revere Date 12/26 1967

6 Oak Grove Medford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 30 December 1967 19..

7 NAME OF FUNERAL DIRECTOR John E. Shea

ADDRESS Dorchester, Mass.

Received and filed DEC 29 1967 19..

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widow

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Joseph M. Mooney (Husband's name in full)

12 AGE 83 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 030 20 7800 T

16 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

17 NAME OF FATHER George McCulloch

18 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass.

19 MAIDEN NAME OF MOTHER Kathleen Dalton

20 BIRTHPLACE OF MOTHER (City) (State or country) ? Canada

21 Informant Joseph P. Mooney

(Address) 465 Boulevard Revere, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (mck)
(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67
(Official Designation) (Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN -2 '68 AM

OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

filed for burial permit
th Board of Health
or its Agent.

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

RINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

This does not mean mode of dying, h as heart failure, henia, etc. It means disease, or compli- ions which caused th.

Conditions, if any, which gave rise to above cause (a), tating the under- ying cause last.

Conditions contrib- ng to death but not ated to the terminal ease condition given (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 274

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. BAY VIEW NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FRANCES L SULLIVAN (GORMAN) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 31 LOWELL RD St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death 5 years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC. (Month) 26 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1960, to Dec. 26, 1967

I last saw her live on Dec. 23, 1967 death is said to have occurred on the date stated above, at 3:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerosis & Hypertensive Heart disease	7 YRS
Due To (b) Generalized Arteriosclerosis	8 YRS
Due To (c) —	
OTHER SIGNIFICANT CONDITIONS Cerebral Arterio-sclerosis	4 YRS

Was autopsy performed? No.

What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) M. Traunstein Jr. M. D.

M. TRAUNSTEIN JR. M.D. (Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop, Mass Date 12/26 1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 29 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed DEC 29 1967 19

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) WIDOWED

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of PHILIP E SULLIVAN (Husband's name in full)

12 AGE 79 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation CLERK (Kind of work done during most of working life)

14 Industry or Business: U.S VET ADM.

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS

PARENTS

17 NAME OF FATHER WILLIAM P GORMAN

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER CATHERINE SHEA

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country)

21 Informant WILLIAM P GORMAN

(Address) 31 LOWELL RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (mek)
(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67
(Official Designation) (Date of Issue of Permit)

4-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 275

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JENNIE (ALOSA) FEDERICO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 15 Trenton Street, East Boston, Mass. (City or town and State)

Length of stay: In place of death ..... years 1 months 10 days. In place of residence 25 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 28, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/11, 1967, to Dec 28, 1967

I last saw he alive on 12/28, 1967, death is said to have occurred on the date stated above, at 12:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic papillary

Due To (b) adenocarcinoma

Due To (c) Scalene nodes c̄ metastasis to both lungs. Primary unknown.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH: 9/11/67; Sept 67

Was autopsy performed? no

What test confirmed diagnosis? Scalene biopsy & bronchoscopy.

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) D. D. Potito, M. D.
D D POTITO (Print or Type Name)
(Address) 17A Bennington Date 12/28 1967

6 St Michael's Roslindale
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 2 1968

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella
ADDRESS 971 Saratoga St. E.B.

Received and filed DEC 29 1967 19
John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): WIDOW

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Albert Federico (Husband's name in full)

12 AGE 72 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 001-10-0806A

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Pasquale Alosa

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Laudari Luigina

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Umberto Alosa
(Address) 26 Thurston St. E.B.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (mk)
(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67
(Official Designation) (Date of Issue of Permit)

OM-8-66-943275

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

e filed for burial permit
ith Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
CAUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 276

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anthony M. Cianci
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 111 Neptune Road St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death ....years 5 months ....days. In place of residence 36 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 30 (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan., 1966, to Dec. 30, 1967.
I last saw him alive on Dec. 29, 1967 death is said to have occurred on the date stated above, at 2400 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebrovascular heart disease — 1yr.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Parkinson's Disease — 6yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify No

(Signature) Charles Melone, M. D.
CHARLES MELONI
(Print or Type Name)
(Address) 45 Bryant St. E. Bostn Date 12-30 1967

Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 2nd 1968

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed January 2, 1968

John A Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Margaret M. Loschi
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 76 Years 5 Months 17 Days — If under 24 hours: Hours ... Minutes

13 Usual Occupation Salesman
(Kind of work done during most of working life)

14 Industry or Business: Clothing

15 Social Security No. 022-01-2453

16 BIRTHPLACE (City) East Weymouth (State or country) Mass.

PARENTS

17 NAME OF FATHER Frank Cianci

18 BIRTHPLACE OF FATHER (City) .... (State or country) Italy

19 MAIDEN NAME OF MOTHER Rachela Truda

20 BIRTHPLACE OF MOTHER (City) .... (State or country) Italy

21 Informant Mrs. Margaret Cianci-wife
(Address) 111 Neptune Rd., E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaglione
(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation)

1/2/68
(Date of Issue of Permit)

OM-9-65-941327

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JAN -2 '68 AM
OFFICE OF CLERK
WINTER

FORM R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

277

NEWTON (City or Town making this return)

Registered No. 647-67

1 PLACE OF DEATH: MIDDLESEX (County); NEWTON (City or Town)

No. 21 Lindbergh Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Florence M. O'Hara (Monahan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence (Usual place of abode) No. 21 Lindbergh Avenue St. Newton, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 15 years — months — days. In place of residence 15 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 19 (Day) 1967 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic Heart Disease
with Hypertension & Coronary Sclerosis
Found Dead in Bed

5 Accident, suicide, or homicide (specify) No

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) PeterAngelo, M. D.

(Address) 820 Main Street Waltham Date Dec.19, 19 67

7 Place of Burial or ~~Cremation~~ Winthrop Cemetery Winthrop (City or Town)

DATE OF BURIAL December 23, 19 67

8 NAME OF FUNERAL DIRECTOR Arthur J. O. Maley

ADDRESS Winthrop, Mass.

Received and filed January 8, 19 68

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR: White

11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Patrick O'Hara
(Husband's name in full)

13 AGE 74 Years 3 Months — Days; If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: Own Home

16 Social Security No. 014 - 22 - 3122A

17 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

18 NAME OF FATHER: John B. Monahan

19 BIRTHPLACE OF FATHER (City) Cannot be Learned (State or country) Ireland

20 MAIDEN NAME OF MOTHER: Catherine Kelley

21 BIRTHPLACE OF MOTHER (City) Cannot be Learned (State or country) Ireland

22 Informant (Address) Patrick O'Hara Husband
21 Lindbergh Ave., West Newton, Mass.

A TRUE COPY
ATTEST: Joseph H. Kurlm
(Registrar of City or Town where death occurred)

DATE FILED December 27, 19 67

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE	April 3, 1918
DATE OF DISCHARGE	July 13, 1919
RANK, RATING	Yoeman 1st Class
ORGANIZATION AND OUTFIT	U. S. Navy
SERVICE NUMBER	1-443-494

JAN -8 58 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers (City or Town making this return)

Registered No. 278

1 PLACE OF DEATH: Essex (County) — Danvers (City or Town)

No. Danvers State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fannie Katz (Fannie Goldstein)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 80 Crest Avenue St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death ....years 4 months 24 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 22, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 28, 1967, to December 22, 1967

I last saw her alive on December 22, 1967, death is said to have occurred on the date stated above, at 2:45 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Viral pneumonia	days
Due To (b)	Arteriosclerotic heart disease	yrs.
Due To (c)	Generalized arteriosclerosis	yrs.
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? No

What test confirmed diagnosis? Clinical&Laboratory

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 12-22-67

6 Tiferoth Israel Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 23, 1967

7 NAME OF FUNERAL DIRECTOR Levine Funeral Chapel

ADDRESS Brookline, Mass.

Received and filed JAN 8 1968, 19....

John A Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Abraham F. Katz
(Husband's name in full)

12 AGE 78 Years 10 Months 23 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: ....

15 Social Security No. 028-01-9734

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Samuel Goldstein

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Etta Brenze

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED December 29, 1967

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

JAN - 8 '68 AM

OFFICE OF THE TOWN CL
WINTHROP, MASS.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

279

TEWKSBURY HOSPITAL
(City or Town making this return)

Registered No. 231

1 PLACE OF DEATH
Middlesex (County)
Tewksbury, Mass. (City or Town)
No. TEWKSBURY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nellie M. Nelsson
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence. No. 152 Pleasant St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 21 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 12, (Day) 1967 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1967, to Dec. 12, 1967
I last saw her alive on Dec. 11, 1967 death is said to have occurred on the date stated above, at 6:55 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 15 Hrs.

Due (b) Gen. & Cerebral Arteriosclerosis — Yrs.

Due To (c) ---------

OTHER SIGNIFICANT CONDITIONS Gouty Arthritis
Paget's Dis. of Skull

Was autopsy performed? No
What test confirmed diagnosis? Clinical & X-Ray

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Lois B. Crowell, M. D.

(Address) TEWKSBURY HOSPITAL Date 12-12-67 19

6 Place of Burial or Cremation Winthrop Cem., Winthrop, Mass. (City or Town)
DATE OF BURIAL December 14, 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynold
ADDRESS 150 Winthrop St., Winthrop

Received and filed JAN. - 9 1968 19
Supt.
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced
HUSBAND of ------
(Give maiden name of wife in full)
(or) WIFE of Nels R. Nelsson
(Husband's name in full)

12 AGE 76 Years 1 Months 11 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. 019-28-5065 JI

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Eugene Lewis

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Maine

19 MAIDEN NAME OF MOTHER Jessie P. Spears

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Maine

21 Informant Hospital Records
(Address)

A TRUE COPY
ATTEST: Supt.
(Registrar of City or Town where death occurred)
DATE FILED 12-12-67 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

JAN - 9 '68 AM

OFFICE OF THE TOWN CLERK
WINTHROP MASS

FORM R-306

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. See reverse side for affidavit.

10M-12-64-939354

OUT-OF-TOWN

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

AFFIDAVIT AND CORRECTION OF A RECORD OF DEATH

280

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town); No. 505 Boulevard ~~XX~~ Ward

Revere (City or town making return)

Registered No. 232
Dep.#58-Bk.#1
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward Gershman (If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran, specify WAR) WW II

(a) Residence. No. 207 Revere St., ~~XXXX~~ Winthrop (Usual place of abode) (If nonresident give city or town and state)

Length of stay: In hospital or institution ..... years months days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Bella Linsky (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 43 years

7 IF STILLBORN, enter that fact here.

8 AGE 45 Years 3 Months 7 Days — If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Asst. Stock Clerk

10 Industry or Business: Lechmere Sales

11 Social Security No. 016-12-0951

12 BIRTHPLACE (City) (State or country): Cambridge Mass.

PARENTS

13 NAME OF FATHER: Philip Gershman

14 BIRTHPLACE OF FATHER (City) (State or country): Russia

15 MAIDEN NAME OF MOTHER: Jennie Eisenman

16 BIRTHPLACE OF MOTHER (City) (State or country): Russia

17 Informant (Address): Bella Gershman, 207 Revere St. Winthrop — Relation, if any: (wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Harry H. Schwartz, M. D.
(Signature of Agent of Board of Health or other)

Chairman (Official Designation) 5/14/67 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 13, (Day) 1967 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 13, 1967, to May 13, 1967

I last saw h..... alive on ....., 19....., death is said to have occurred on the date stated above, at 7:40P m.

Immediate cause of death: Coronary Occlusion -sudden

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? Clinical

Duration

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) Benjamin L. Weinstein, M. D.
(Address) 1520 No. Shore Rd. Revere Date 5/14 1967

21 Klevaner Everett
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 15, 1967

22 NAME OF FUNERAL DIRECTOR Stanetsky Mem. Chap.
ADDRESS 1668 Beacon St., Brookline

Received and filed May 17 1967

A TRUE COPY ATTEST: Joseph H. Weinstein (Registrar)

DEPOSITION

WRITE LEGIBLY WITH DURABLE BLACK INK

SEP -6 '68 AM
OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

The Commonwealth of Massachusetts
County of Suffolk } ss.:

The undersigned, being duly sworn, depose and say that the record relating to the death of Edward Gershman (Give name of decedent exactly as recorded on the original record) in the city (City or town) of Revere (Name of city or town), does not fully and correctly state all the facts relating to said death, and that the true statement of facts omitted or incorrectly stated in said record has been supplied by her (Him or her) on the form of certificate on the other side of this blank.

SIGNATURE	RESIDENCE (City or town, street and number, if any)	Relation to decedent, if any
(s) Bella Gershman	207 Revere St., Winthrop	Wife

FURTHER, The written evidence submitted to substantiate the affidavit was:
Cert. of residence from town Clerk, Winthrop

Date, Sept. 4, 1968

Then personally appeared before me the person whose signature appear above and made oath that the statements subscribed to by her are true.

Name (s) Joseph F. McChristal

Official designation City Clerk
(City or town clerk or assistant clerk)

MARGIN RESERVED FOR BINDING

#281

Charles S. Strasser

Decree re Death - All papers filed in folder under Death Cards. -